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Pamphlet 600–24

Personnel-General

Health Promotion, Risk Reduction, and Suicide Prevention

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SUMMARY of CHANGE

DA PAM 600-24

Health Promotion, Risk Reduction, and Suicide Prevention

This major revision, dated 14 April 2015--

- o Reorganizes the content of chapters 2, 3, and 4 to facilitate clarity of content (chaps 2, 3, 4).
- o Adds guidance on the HQDA Specialized Suicide Augmentation Response Team/ Staff Assistance Team (para 2-1e).
- o Introduces the use of the DA Form 7747 (Commander's Suspected Suicide Event Report) as an official Army form and replaces all references to "CSSER (Commanders Suspected Suicide Event Report)" with the DA Form 7747 (para 2-9d and throughout).
- o Introduces "ACE-SI" as the appropriate nomenclature for ACE suicide intervention training and provides guidance on its use and applicability (para 4-5 and throughout).
- o Implements the use of DD Form 2996 (Department of Defense Suicide Event Report) as an official DOD form and replaces all references to "DODSER (Department of Defense Suicide Event Report)," with the DD Form 2996 (para 5-2 and throughout).
- o Replaces chapter 9 and removes the accompanying appendix, Army Campaign Plan for Health Promotion, Risk Reduction and Suicide Prevention compliance checklist (chap 9 and app G).
- o Adds additional resources to appendix D and removes Military OneSource from the list of hotlines (app D).
- o Replaces the term "DA Civilians" with "Army Civilians" (throughout).

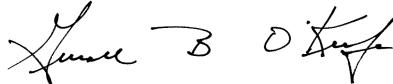
Personnel-General

Health Promotion, Risk Reduction, and Suicide Prevention

By Order of the Secretary of the Army:

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General, United States Army
Chief of Staff

Official:



GERALD B. O'KEEFE
Administrative Assistant to the
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History. This publication is a major revision.

Summary. This pamphlet explains the procedures for health promotion, risk reduction, and suicide prevention efforts to mitigate high-risk behaviors.

Applicability. This pamphlet applies to the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve, unless otherwise stated.

Proponent and exception authority.

The proponent of this pamphlet is the Deputy Chief of Staff, G-1. The proponent has the authority to approve exceptions or waivers to this pamphlet that are consistent with controlling law and regulations. The proponent may delegate this approval authority, in writing, to a division chief within the proponent agency or its direct reporting unit or field operating agency, in the grade of colonel or the civilian equivalent. Activities may request a waiver to this pamphlet by providing justification that includes a full analysis of the expected benefits and must include formal review by the activity's senior legal officer. All waiver requests will be endorsed by the commander or senior leader of the requesting activity and forwarded through their higher headquarters to the policy proponent. Refer to AR 25-30 for specific guidance.

Interim changes. Suggested improvements.

Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Deputy Chief of Staff, G-1 (DAPE-HRI), 200 Army Pentagon,

Washington, DC 20310-0300. Committee Management. AR 15-1 requires the proponent to justify establishing/continuing committee(s), coordinate draft publications, and coordinate changes in committee status with the U.S. Army Resources and Programs Agency, Department of the Army Committee Management Office (AARP-ZA), 9301 Chapek Road, Building 1458, Fort Belvoir, VA 22060-5527. Further, if it is determined that an established "group" identified within this regulation, later takes on the characteristics of a committee, as found in the AR 15-1, then the proponent will follow all AR 15-1 requirements for establishing and continuing the group as a committee.

Distribution. This pamphlet is available in electronic media only and is intended for command levels C, D, and E for the Active Army, the Army National Guard/Army National Guard of the United States, and the U.S. Army Reserve.

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Glossary

Chapter 1 Introduction

1–1. Purpose

This pamphlet sets forth procedures for establishing health promotion, risk reduction, and suicide prevention efforts. It provides holistic guidance to improve the physical, behavioral, spiritual, environmental, and social health of Soldiers, Army Civilians, and their Families.

1–2. References

Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms

Abbreviations and special terms used in this pamphlet are listed in the glossary.

Chapter 2 Key Roles, Functions, and Structure

2–1. The Army Suicide Prevention Program

a. The Army Suicide Prevention Program (ASPP), a proponent of Deputy Chief of Staff, G–1 (DCS, G–1), has an Armywide commitment to provide resources for suicide intervention skills, prevention, and follow-up in an effort to reduce the occurrence of suicidal behavior across the Army enterprise. The ASPP manager also serves as a member of the Department of Defense (DOD) Suicide Prevention and Risk Reduction Committee and subcommittees to ensure the ASPP is aligned with the Defense Centers of Excellence. The ASPP develops initiatives to tailor and target policies, programs, and training in order to mitigate risk and behavior associated with suicide. A function of the ASPP is to track demographic data on suicidal behaviors to assist Army leaders in the identification of trends. The goal is to minimize suicidal behavior by reducing the risk of suicide for Active Army and Reserve Component Soldiers, Army Civilians, and Army Family members. The ASPP establishes a community approach to reduce Army suicides through the function of the Community Health Promotion Council (CHPC). The CHPC integrates multidisciplinary capabilities to assist commanders in implementing local suicide prevention programs, and establishes the importance of early identification of, and intervention with, problems that detract from personal and unit readiness. The ASPP has three principal phases or categories of activities to mitigate the risk and impact of suicidal behaviors: prevention, intervention, and postvention.

b. Prevention focuses on preventing normal life stressors from turning into life crises. Prevention programming focuses on equipping the Soldiers, Army Civilians, and Family members with coping skills to handle overwhelming life circumstances. Prevention includes early screening to establish baseline behavioral health and to offer specific remedial programs before dysfunctional behavior occurs. Prevention is dependent upon caring and proactive unit leaders and managers who make the effort to know their personnel, including estimating their ability to handle stress, and who offer a positive, cohesive environment which nurtures, and develops positive life-coping skills. These “gatekeepers” serve as the first line of defense to mitigate risk (see glossary for “gatekeeper” explanation). Prevention plays a crucial role in mitigating issues before intervention becomes necessary.

c. Intervention includes alteration of the conditions that produced the current crisis, treatment of underlying psychiatric disorder(s) that contributed to suicidal thoughts, and follow-up care to assure problem resolution. This includes measures taken to ensure safe environments, to include the use of a buddy system or Unit Watch. Commanders play an integral part during this phase, as it is their responsibility to ensure access to appropriate health care and ensure the safety of assigned personnel.

d. Postvention is required when an individual has attempted or completed a suicide. After an attempt, commanders, noncommissioned officers (NCOs), and installation gatekeepers should take steps to secure and protect such individuals before they can cause additional harm to themselves or harm others. Postvention activities also include unit-level interventions following completed suicidal acts, to minimize psychological reactions to the event, prevent or minimize potential for suicide contagion, strengthen unit cohesion, and promote continued mission readiness.

e. The Headquarters, Department of the Army (HQDA) Specialized Suicide Augmentation Response Team (SSART) and Staff Assistance Team (SAT) is a quick response, DCS, G–1 led, multidisciplinary team that is available to commanders (at commanders’ request or DCS, G–1 directed) for cluster suicide events.

f. A representative from DCS, G–1, Suicide Prevention Program Office serve as the lead for assembling the SSART and SAT and membership is predicated on the needs of the involved commanders. At a minimum, each team consists of a behavioral health professional, chaplain, G–3/5/7 representative, and command personnel.

g. The SSART and SAT is not an inspection team, but an augmentation team to assist local commanders and staff to identify gaps in policies and services and offer recommendations for improvement.

h. The Office of the Surgeon General, in conjunction with installation CHPCs, develop a specific plan to provide

commanders additional guidance on ensuring at risk medications are tracked and medical peer review is completed through quality assurance. Guidance provides commanders with information on how to—

- (1) Track at risk medications when the health care provider (HCP) or pharmacy will not release their medication information.
- (2) Determine how the Army tracks medication filled by an outside DOD medical pharmacy.

2–2. Army Suicide Prevention Program strategy

a. The strategy and supporting elements of the ASPP are based on the premise that suicide prevention is accomplished by leaders through command policy and action. The key to the prevention of suicide is positive leadership and deep concern by supervisors of military personnel and Army Civilian employees who are at increased risk of suicide.

b. It is the Army’s goal to prevent suicide among Soldiers, Army Civilians, and Family members. However, in some instances, suicidal intent is very difficult to identify or predict, even for a behavioral health professional. Suicides may still occur even in units with the best leadership climate and most efficient crisis intervention and suicide prevention programs. Therefore, it is important to redefine the goal of suicide prevention as being suicide risk reduction. Suicide risk reduction consists of reasonable steps taken to lower the probability that an individual may engage in acts of self-destructive behavior.

c. The ASPP provides support for commanders to lower the risk of suicide for Soldiers, Army Civilians, and Family members.

d. The ASPP ensures that the effectiveness and implementation of programs are supported by the best available scientific research by comparing them to the Army Institute of Public Health’s standards of evidence-based practice for health promotion programs or other registries of effective public health programs.

2–3. Leadership

The success of a health promotion, risk reduction, and suicide prevention program depends on the concentrated focus of leadership on activities that encompass the physical, emotional, social, spiritual, and family dimensions in their respective communities. The total effect of a solid program is an overall improvement in unit and organizational performance by enhancing individual well-being.

a. Leaders need to know their subordinates and assure that timely assistance is provided when needed.

b. Commanders and Army Civilian leaders establish standardized protocols so that individuals identified as having increased risk are referred to appropriate agencies to receive help. Examples include Community Behavioral Health Services (CBHS), emergency room or medical treatment facility, local hospital, chaplain or Employee Assistance Program.

c. Progress is tracked by the unit commander and/or supervisor to ensure that the problem is resolved.

2–4. Commanders

Commanders play a vital role in establishing and enforcing policies and standards that are consistent with Army Values and supportive of mission accomplishment. See Army Regulation (AR) 600–63 for a listing of specific responsibilities.

2–5. Soldiers

- a.* Live up to the Army Values in caring for a buddy.
- b.* Seek out a buddy for advice, protection, and support.
- c.* Recognize that seeking help is a sign of strength.
- d.* Report all concerns that a buddy may harm him or herself.

2–6. First-line supervisors

- a.* Promote a climate of support, minimize stigma, and encourage help-seeking behavior.
- b.* Understand leader responsibilities regarding suicide prevention, intervention, and postvention.
- c.* Take a personal interest in, and know, what is going on in subordinate Soldiers’ personal lives and provide support, when needed.
- d.* Teach suicide prevention to all Soldiers in chain of command.
- e.* Implement the battle buddy system.
- f.* Foster a sense of responsibility in Soldiers to provide watchful care and support to peers.

2–7. Chaplains

a. Chaplains collaborate with behavioral health professional in units, Combat Stress Control Teams, and with Military Family Life Consultants (MFLCs) to provide multidisciplinary support, normalize referrals, and reduce stigma associated with help-seeking behavior.

b. Chaplains, chaplain assistants, and civilians who work in support of the Chaplain Corps provide comprehensive religious support services that are designed to enhance resilience and readiness. Strong Bonds is one of the cornerstone resilience programs that has evolved over time to strengthen Soldiers and Army Families. Strong Bonds is a chaplain-

led, command-initiated program resourced through the Office of the Chief of Chaplains and is conducted during duty hours, after duty hours and on weekends. Training programs are offered for single Soldiers, couples, and Family members; attendance is voluntary. During the training, Soldiers and Families participate in small group activities that strengthen relationship bonds, nurture resiliency, and support long-distance relationships. In addition, Soldiers and Families gain awareness of community resources that can assist with concerns about health and wellness, even crisis intervention. Strong Bonds programs are available to all Active Army, Army National Guard (ARNG), and United States Army Reserve (USAR) Soldiers and their Families.

2–8. Military Family Life Consultants

MFLCs are managed and deployed by the Office of the Secretary of Defense (OSD). They are professionals in private practice in the state in which they are licensed. When MFLCs come on board under contract with OSD, they become consultants at a specific location. MFLCs are available to Soldiers and Families, are incorporated into commander and/or unit programs, and are fully integrated with other providers, such as tri-service medical care (TRICARE) network or medical treatment facility HCPs, to ensure seamless coverage between contact and referral.

2–9. Criminal Investigation Command commanders or special agents in charge of the supporting U.S. Army Criminal Investigation Command element

Criminal Investigation Command (CID) commanders or special agents in charge of the supporting U.S. Army Criminal Investigation Command (USACIDC) element—

- a.* Investigate all suicides or suspected suicides of Soldiers (see AR 195–2).
- b.* Establish liaison with local civilian law enforcement agencies, coroners, and medical examiners, as appropriate, to obtain information regarding suicide-related events involving military personnel, their Families, or Army Civilians, which may have occurred off-post, and provide such information to the Suicide Prevention Task Force (SPTF) and AR 15–6 investigating officer.
- c.* As allowed by appropriate regulations, provide the Senior Commander, SPTF and AR 15–6 investigating officer extracts from the USACIDC reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.
- d.* Coordinate with commanders regarding equivocal death investigations to ensure commanders take appropriate, timely actions (AR 15–6 and/or line of duty, and so on), in the event that the equivocal death is determined to be a suicide. The local CID element investigating the event assists commanders by providing data in support of completing the DA Form 7747 (Commander’s Suspected Suicide Event Report).

2–10. Line of duty investigating officers

- a.* Line of duty investigating officers are appointed in accordance with AR 600–8–4.
- b.* Perform a line of duty determination for all deaths and injuries arising from suicide-related events (equivocal deaths, attempts, and acts of self-harm) for Soldiers in an active duty or inactive duty training (IDT) status in accordance with AR 600–8–4.
- c.* Coordinate and communicate with an appropriate medical treatment facility behavioral health officer to obtain an opinion from that officer regarding whether the Soldier who died of suicide was “mentally sound” at the time of the suicide incident. The DA Form 7747 may aid in the determination and in future statistical analysis of Army suicides.

2–11. Community Health Promotion Council

The roles and responsibilities of the CHPC are outlined in AR 600–63. CHPCs are tasked with the responsibility to oversee health promotion, Ready and Resilient Campaign (R2C) and well-being programs for their installations, State Joint Forces Headquarters (JFHQ) and USAR direct reporting units (DRUs) and/or major subordinate commands, and are chaired by the senior commander, Army command (ACOM), Army service component command (ASCC), and/or DRU commander, the State Adjutant General, or a designee, as appropriate.

2–12. Suicide Prevention Task Force

- a.* The SPTF is a sub-committee of the CHPC where one exists. The membership of this committee should be tailored to meet local needs.
- b.* The SPTF should consist of the following personnel or their local equivalent:
 - (1) The Suicide Prevention Program Manager (SPPM).
 - (2) The Alcohol Drug Control Officer (ADCO) and/or Army Substance Abuse Program (ASAP) Manager.
 - (3) The chaplain.
 - (4) The Director of Health Services.
 - (5) The health promotion officer
 - (6) The division and/or command surgeon.
 - (7) The Chief, CBHS.
 - (8) The Division Behavioral Health Officer and/or Director of Psychological Health.

- (9) The public affairs officer.
- (10) The Director, Human Resources.
- (11) The Provost Marshal.
- (12) Commander or special agent-in-charge of supporting USACIDC element.
- (13) The Staff Judge Advocate.
- (14) The Army Community Services (ACS) officer.
- (15) The Director of Family, Morale, Welfare, and Recreation.
- (16) The Director of Plans and Training.
- (17) A representative of the post Family member schools.
- (18) Other installation, organization, and community agencies, as needed.

2-13. Suicide Prevention Task Force functions

- a.* The SPPM serves as the presiding officer over the SPTF and performs other duties as specified in AR 600-63.
- b.* The ADCO and/or ASAP Manager—
 - (1) Serves as the task force presiding officer in the absence of the SPPM.
 - (2) Advises the commander regarding the impact of alcohol and drug abuse on suicide risk.
 - (3) Assures that ASAP staff is trained in suicide risk identification factors and in the management of at-risk clients.
 - (4) Informs the task force of the current ASAP training requirements of the command and estimates the impact of their requirements on the quality of life within the area served by the task force.
- c.* The health promotion officer—
 - (1) Provides expertise and input for health promotion policy.
 - (2) Synchronizes task force efforts with CHPC.
- d.* The chaplain—
 - (1) Advises commanders on moral and ethical issues and other stress factors that may result in an increased risk.
 - (2) Assures that all chaplains and chaplain assistants within the command are trained to identify individuals who may be at increased risk of suicide and make appropriate referrals. This training is conducted with the assistance of local behavioral health officers.
 - (3) Provides the training expertise to assist the commander in the education-awareness training process. Unit chaplains and chaplain assistants provide and assist in unit-level suicide prevention training for the Army Family (leaders, supervisors, Soldiers, and Army Civilians). Chaplains advise and assist other staff members and task force members in satisfying identified training needs.
- e.* The Director of Health Services—
 - (1) Assesses and advises the installation commander on stress factors that may result in increased numbers of persons at risk.
 - (2) Provides behavioral health officers to train other trainers in the education-awareness program.
- f.* The command surgeon at other headquarters echelons—
 - (1) Assures that HCPs are trained in crisis intervention techniques using periodic in-service education.
 - (2) Serves as liaison with the medical department activity Behavioral Health Service and the Division Mental Service.
 - (3) Coordinates training activities with the chaplains.
- g.* The ACS officer—
 - (1) Serves as the staff officer to coordinate the Family Member Suicide Prevention Training.
 - (2) Continues operation of advocacy and out-reach programs dealing in areas of stress and Family violence.
 - (3) Informs the public affairs officer of community support resources to heighten public awareness of helping mechanisms available within the community.
 - (4) Conducts appropriate in-service training of ACS staff members, including volunteers who routinely assist Soldiers, Army Civilians, and Family members who might be at risk of suicide.
 - (5) Emphasizes support agencies and programs during Family member orientations and other appropriate briefings.
 - (6) Serves as the specific task force participant responsible for coordinating with civilian support agencies.
- h.* The public affairs officer—
 - (1) Provides advice and counsel in effective communication planning and execution.
 - (2) Collaborates, integrates and synchronizes the community awareness needs for health promotion and R2C initiatives with other on-going communication efforts.
- i.* The Provost Marshal—
 - (1) Ensures law enforcement forces respond to potential suicide situations discretely and cautiously to avoid increasing stress for the personnel in suicidal crisis (that is, normally the use of emergency equipment (lights or sirens) would be inappropriate).

(2) Provides feedback information to the task force, as appropriate, on any suicide-related events that may have occurred on post.

(3) Reinforces instruction presented at the U.S. Army Military Police School concerning identification of persons at risk for suicide, and emphasizes that actions taken by law enforcement in the line of duty may cause some people to be at increased risk of suicide. An example might be a teenager who has been arrested for shoplifting and is greatly embarrassed about his or her behavior. Awareness training, using the assistance and advice of chaplains and behavioral health professionals, may be conducted at in-service training and professional development classes.

j. Commander or special agent-in-charge of the supporting USACIDC element—

(1) Investigates all suicides or suspected suicides (see AR 195–2).

(2) Establishes liaison with local civilian law enforcement agencies, coroners, and medical examiners, as appropriate, to obtain information regarding suicide-related events involving military personnel, their Families, or Army Civilians, which may have occurred off-post, and provide such information to the task force.

(3) As allowed by appropriate regulations, provides the task force with extracts from the CID reports of investigation (including psychological autopsy), which may be useful in understanding the reasons for a suicide and in formulating future prevention plans.

k. The Staff Judge Advocate—

(1) Provides suicide prevention awareness training for personnel assigned to the Office of the Staff Judge Advocate and legal assistance attorneys with the advice and assistance of chaplains and behavioral health professionals. In the course of performing their duties, legal assistance attorneys and victim witness liaisons may provide assistance to Soldiers, Family Members, and, in limited circumstances, Army Civilians, who are in crisis, not only from administrative and legal actions, but also from other causes. Such crises may cause them to be at increased risk of suicide.

(2) Functions as “secondary gatekeepers” for at-risk personnel. Gatekeepers are individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers in need. The roles of legal assistance attorneys and victim witness liaisons are unique in that communications with clients are privileged and, therefore, confidential. The protection afforded by this confidentiality facilitates the client’s disclosure of his or her innermost thoughts, secrets, concerns, and troubles to his or her lawyer. Ensuring client confidentiality for at-risk Soldiers with legal problems is critical for their access to behavioral health assistance and suicide prevention.

(3) Ensures rights protection supports the safety of at-risk personnel. Any Soldier identified by legal assistance attorneys and victim witness liaisons as a potential suicide risk should be escorted immediately to behavioral health. In instances where Soldiers are referred to behavioral health by their legal assistance attorneys and victim witness liaisons, all communications made by the Soldier and/or legal assistance attorneys and victim witness liaisons during the intake and all subsequent treatment, evaluation, therapy, counseling, and/or appointments of any type is confidential in the same manner as if the servicing behavioral health provider was part of the defense team in accordance with Military Rule of Evidence 502(a). For Soldiers with legal assistance attorneys and victim witness liaisons and pending Uniform Code of Military Justice (UCMJ) or adverse administrative action, the servicing behavioral health provider may be appointed by the convening authority to the defense team as a consulting behavioral health expert upon request of the defense in accordance with Rules for Court Martial 703(d). The servicing behavioral health provider maintains confidentiality regardless of the convening authority’s action on the request.

l. The Director, Human Resources—

(1) Assures that local programs take into consideration the needs of the Army Civilian work force.

(2) Is responsible for coordinating the training for Army Civilian managers and supervisors.

m. The Director, Family, Morale, Welfare, and Recreation—

(1) Serves as the point of contact for program information and advice to the commander and to major subordinate commands.

(2) Integrates suicide prevention into community, Family, and Soldier support programs, as appropriate.

n. The Director, Plans and Training—

(1) Informs the task force of the current training and operational requirements of the command and estimates the impact of their requirements on the quality of life within the area served by the task force.

(2) Develops schedules for all training and operational requirements.

2–14. Risk Management Team

Army divisions and other large activities with adequate support should consider establishing a Risk Management Team. This is an optional element of the ASPP. The team is charged with the responsibility of addressing the medical and administrative needs presented by high-risk cases. The Risk Management Team does not get involved in rescue or emergency lifesaving operations with respect to suicide attempts. It is the role of the Risk Management Team to address those problems and issues that precipitated the suicide attempt and to deal expeditiously with them.

2–15. Suicide Response Team

The Suicide Response Team (SRT) convenes at the discretion of the commander as a result of an attempted or completed suicide. As an adjunct to the CHPC, its function is to assist the commander in assessing the situation,

determining appropriate courses of action, directing immediate interagency and interstaff actions, and advising the commander. See AR 600–63 for specific information regarding team intervention and composition.

a. The Command Surgeon or Director of Psychological Health—

- (1) Assumes primary responsibility as the SRT coordinator.
- (2) Provides for the clinical evaluation, treatment, and disposition of Soldiers who may be at increased risk for suicide.
- (3) Provides active multidisciplinary coordination for the medical, administrative, and legal needs of the at-risk individual, utilizing to the fullest extent possible the services provided by other team members, medical treatment facilities, and existing human resource agencies.
- (4) Serves as the primary point of contact during a suicide crisis for battalion and separate company commanders to convene the SRT.
- (5) Institutes all necessary management procedures internal to the division and executes, as necessary, memoranda of understanding with medical treatment facilities to ensure that immediate and appropriate actions are taken in response to a suicide attempt.

(6) Provides for collection, evaluation, and dissemination of all data pertaining to attempted suicides or suicide related behavior. Family members of the deceased have privacy rights that are protected under the Privacy Act (Title 5, Section 552a of the United States Code (5 USC 552a)). Any decision to release information should adhere to these rights and protect the military interest.

(7) Coordinates the use of medical assets in the training of stress management, suicide prevention, and Family advocacy subject matters.

b. The Command Psychiatrist or Senior Behavioral Health Officer—

- (1) Serves as the alternate coordinator in crisis situations in the absence of the Command Surgeon, and as the principal point of contact with medical treatment facilities as a member of the SRT.
- (2) Provides for the clinical evaluation, treatment, and disposition of military personnel who may be at increased risk for suicide.

(3) Provides for training in stress management, suicide prevention, and Family advocacy subject matters.

(4) Provides battalion and separate company commanders with information about Soldiers who may be at increased risk of suicide when it is necessary for the commander to take action to protect a Soldier or civilian.

(5) Disseminates an epidemiologic profile that serves as a standard by which members of the chain of command can identify potential suicides.

(6) Assists command surgeon in the collection and analysis of suicide-related behavioral data.

c. The command chaplain representative—

- (1) Is available with the division and/or command surgeon during a suicide crisis, upon request.
- (2) Develops policies and procedures for unit chaplains to ensure an active monitoring of high risk Soldiers and provides for chaplain intervention during a suicide crisis.
- (3) Provides immediate pastoral assistance to Families who have suffered a suicide or suicide attempt.
- (4) Assists the division and/or command surgeon in providing training in stress management, suicide prevention, and Family relationship issues to Soldiers.

d. The Deputy Chief of Staff, G–1 and/or Adjutant General Corps personnel representative—

- (1) Is available during a suicide crisis when requested by the division and/or command surgeon.
- (2) Supports the division and/or command surgeon in the collection, analysis, and dissemination of suicide-related behavioral data.
- (3) Formulates letters of instruction, regulations, and so on, as required, to prescribe appropriate procedures and activities which foster suicide prevention and intervention.
- (4) Coordinates with the battalion or separate company commander concerned and provides advice or administrative assistance, as required.

e. The provost marshal representative—

- (1) Is available during a suicide crisis when requested by the division and/or command surgeon.
- (2) Ensures procedures are established for immediate notification of the operations center, the division and/or command surgeon, and the appropriate commander during instances when Soldier suicides or Family member suicides are imminent or have occurred. Also coordinates directly with medical treatment facilities in crisis situations (emergency rooms) as appropriate or necessary.
- (3) Provides for immediate protection and well-being of Soldiers, Army Civilians, or Family members at high risk for suicide until unit or medical personnel are on the scene.

f. Representatives of the Staff Judge Advocate, Alcohol Drug Control Officer and/or Army Substance Abuse Program Manager, and an Army Community Service officer—

- (1) Are available during a suicide crisis when requested by the surgeon.

(2) Provide advice and assistance to the division and/or command surgeon within their areas of administrative or professional expertise on matters pertaining to suicide risks or attempts.

2-16. Other programs, entities, resources, and personnel

a. The Risk Reduction Program (RRP), established by the ASAP is a tool to help commanders reduce high-risk behavior in their Soldiers. It has evolved into an efficient way of assisting commanders in ascertaining and addressing high-risk behavioral problems. Using the RRP, commanders can call upon installation resources for support in reducing or preventing high-risk behaviors from impacting mission readiness. It promotes a prevention-focused approach when dealing with suicidal and/or high-risk behaviors and promotes focused, coordinated actions on the part of the installation agencies and the chain of command in units with potentially high-risk profiles. The ADCO and/or ASAP Manager serves as the local proponent for the RRP.

b. Commanders determine interventions after monthly or quarterly consultations using their own chain of command and available installation expertise, including the Installation Prevention Team (IPT) to solve issues. The Risk Reduction Program Coordinator facilitates development and delivery of risk reduction products from installation activities for mission commanders.

c. The IPT is composed of many representatives from the installation human services agencies such as the ASAP, Family Advocacy Program (FAP), ACS, preventive medicine, chaplain, and the Staff Judge Advocate. The focus of the IPT is to review and analyze the installation's risk reduction unit data and, in collaboration with commanders, develop prevention strategies and interventions to address high-risk factors affecting units. IPT members also collaborate to develop and implement Installation Prevention Plans. See AR 600-85 for specific details regarding the IPT.

d. The Risk Reduction Program Coordinator (RRPC) is the subject matter expert on high-risk behaviors captured in the RRP and serves as the commander's consultant. The RRPC interfaces directly with risk managers of installation units and activities as the facilitator of the IPT in order to oversee data collection, processing, and analysis to produce tailored, timely, and accurate risk assessments and recommend courses of action for mitigation efforts. The RRPC provides an outreach consultation capability that works directly with commanders requiring assistance in developing unit-specific risk management plans.

e. The two prominent tools of the RRP are the unit risk inventory (URI) and the re-integration unit risk inventory (R-URI). These command climate surveys help commanders determine the actual occurrences of high-risk behaviors, not just reported incidences, because the surveys are done anonymously. Combined with data on actual occurrences of high-risk behaviors and the expertise of the IPT, these surveys help installation HCPs target appropriate intervention strategies where they are needed most. Commanders coordinate with the installation ASAP to administer the URI to all deploying Soldiers between 30 to 90 days before an operational deployment, and the R-URI to redeploying Soldiers between 90 and 180 days of their return from deployment. Commanders may coordinate with the installation ASAP to administer the URI to their units at any time; however, incoming commanders should consider this a necessary action during their change of command. See AR 600-85 for more information regarding URI and R-URI dissemination.

f. The Case Review Committee is a multidisciplinary team supervised by the medical treatment facility commander. The Case Review Committee, through Social Work Services, assesses reports of spouse and child abuse, recommends treatment plans, and ensures that each case receives a determination of substantiated or unsubstantiated. The purpose of the Case Review Committee is to coordinate medical, legal, law enforcement, and social work assessment, identification, command intervention, investigation, and treatment functions from the initial report of spouse or child abuse to case closure. A treatment team may handle both spouse and child abuse, or separate teams may be organized to handle each type of abuse. The Case Review Committee is not a public meeting, and membership is limited to those individuals identified in AR 608-18. Members are required to have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse.

g. The Fatality Review Committee reviews all known or suspected domestic violence or child abuse-related homicides and suicides to include all infant and child deaths in which the manner of death is undetermined at autopsy involving any of the following: a Servicemember of the Army on active duty; a current or former Family member or dependent of a Servicemember of the Army on active duty; or a current or former intimate partner who has a child in common or has shared a common domicile with a Servicemember of the Army on active duty. The review should take place after related law enforcement investigations, autopsies, and court trials have ended. The review process is not a public meeting and the attendance is limited to the members of the Fatality Review Committee and consultants, as appropriate. (See AR 608-18, The Army Family Advocacy Program, for additional guidance.)

2-17. Reporting

All committees, teams, and councils report information and data trends to the CHPC on a quarterly basis.

Chapter 3 Prevention

3–1. Suicide prevention

Suicide prevention is a continuum of awareness, intervention, and postvention to help save lives. Prevention refers to all efforts that build resilience, reduce stigma, and build awareness of suicide and related behaviors. Ultimately, the goal of prevention is to develop healthy, resilient Soldiers to the state that suicide is not an option. Prevention focuses on reducing life stressors and intervening when life crises become so overwhelming that suicide becomes a serious consideration. It is important to establish a culture that reinforces and normalizes help-seeking behavior as an appropriate and generally accepted part of being responsible. Training can be provided to improve intervention skills, increase knowledge, and build confidence in Soldiers to respond appropriately to a suicidal threat.

3–2. Factors contributing to suicide

Individuals may have difficulty coping with intense feelings or emotions and consider taking drastic measures to deal with the emotional pain. Strategies to address suicide should include both the mitigation of these intense emotions and the circumstances which lead to them. Most suicides and suicide attempts are reactions to one or more of the following intense feelings:

a. Loneliness: an emotional state in which a person experiences powerful feelings of emptiness and spiritual isolation. Loneliness often stems from feeling disconnected from other people. Loneliness is a feeling of being cut off, disconnected from the world, and alienated from other people. Strengthening an individual's spiritual fitness and building connections with other people is the key to helping individuals withstand grief and loss. This connection allows individuals to rebound from severe disappointments of life.

b. Worthlessness: an emotional state in which an individual lacks any feelings of being valued by others.

c. Hopelessness: a strong sense of futility, due to the belief that the future holds no escape from current negative circumstances. The intensity of this emotion is fed by the belief that no resources exist to bring relief or change the current perception of reality.

d. Helplessness: a condition or event where the Soldier thinks that he or she has no control over his or her situation and that whatever he or she does is futile, such as repeated failures, to include failed relationships.

e. Guilt: a primary emotion experienced by individuals who feel a strong sense of shame associated with actions they believe are wrong.

3–3. Life skills and resiliency

a. Resiliency-building programs help Soldiers and Families develop life skills and directly impact the success of suicide prevention efforts by enhancing protective factors and mitigating stressors at the earliest stages. Life skills classes are available on a wide variety of subjects, to include couples communication, child rearing, money management, stress management, conflict resolution, anger management, and problem-solving. Commanders at all levels are encouraged to work with Comprehensive Soldier and Family Fitness (CSF2), ACS and local agencies to make these classes available to Soldiers and Families.

b. Resiliency is the ability to recover and adapt despite adversity, trauma, illness, changes, or misfortunes. Resiliency means “bouncing back” from difficult situations. Soldier resiliency is a combination of factors, including a sense of belonging in the unit, having inner strength to face adversity and fears, connecting with buddies, maintaining caring and supportive relationships within and outside the Family, maintaining a positive view of self, having confidence in strengths and abilities to function as a Soldier, and managing strong feelings and impulses.

c. The following are some adaptive behaviors, thoughts, and actions that can mitigate the negative effects of trauma, adversity, and emotional stress:

- (1) Attend life skills or related training.
- (2) Seek out a mentor in which to confide.
- (3) Actively and frequently participate in unit activities.
- (4) Join social support groups, faith-based organizations, and self-help groups.
- (5) Recognize, accept, and face fears.
- (6) Nurture good relationships with Family and close friends, which may include counseling.
- (7) Learn to regulate emotions and avoid impulsive behavior.
- (8) Maintain realistic optimism and belief in the ability to survive and function as a good Soldier.
- (9) Recognize that no one has the resources to manage all personal problems alone. Practice help-seeking behavior as a sign of strength.
- (10) Commit to practices that maintain good physical and behavioral health.
- (11) Avoid isolation when faced with stressors.
- (12) Develop and maintain spiritual fitness.

d. Programs and services which support resiliency but do not directly fall under suicide prevention are quite varied. Some of these programs are as follows:

- (1) Yellow Ribbon Re-integration Program.
- (2) Deployment Cycle Support.
- (3) Family Assistance Centers.
- (4) Strong Bonds.
- (5) Marriage and Family Therapist Program.
- (6) Army Emergency Relief Fund.
- (7) ASAP.
- (8) Warrior Transition Units.
- (9) CSF2.
- (10) ACS programs such as Army Family Team Building, Exceptional Family Member Program, FAP, Army OneSource, and others.

3–4. Stigma reduction

One of the greatest barriers to preventing suicides is a culture that shames Soldiers into believing it is not safe to seek help. Stigma can render suicide prevention efforts ineffective unless elements are incorporated into the program to address the cultural and institutional issues that create barriers to help-seeking behaviors.

a. Individuals may not seek help because they believe that their problems or behavioral health issues should remain a secret. Reasons for this may include shame and embarrassment, fear that their careers may be affected, concern that personal issues are exposed, belief that seeking help is a sign of weakness, concern that leadership and fellow Soldiers may treat them differently and feelings of isolation.

b. Keeping personal problems or behavioral health issues a secret can result in the development of depression and anxiety, compounded stressors, degraded ability to think clearly, difficulty making decisions, thoughts of suicide, suicidal attempts, and completed suicides.

c. The stigma associated with receiving behavioral health care takes on an added significance in the Army. In addition to worrying about their careers and suffering embarrassment, Soldiers have the concern that their commander may discover that they are seeking treatment. Commanders have a legitimate “need to know” about the behavioral health and physical capabilities of their Soldiers in order to safely and efficiently carry out their mission. However, Soldiers may feel they cannot acknowledge the need for help without negatively impacting their careers. To combat the belief that seeking help is a sign of weakness, commanders are encouraged to reinforce the personal courage it takes to seek behavioral health help.

d. To be effective, any initiative taken to reduce stigma should address actual and perceived stigma of seeking help. Stigma is a cultural issue that requires deliberate and focused effort to overcome. The key to stigma reduction is leadership emphasis at all levels. Leaders can accomplish this by:

- (1) Seeking help when needed.
- (2) Eliminating policies that discriminate against Soldiers who receive behavioral health or other forms of counseling.
- (3) Supporting confidentiality between the Soldier and his or her behavioral HCP.
- (4) Removing organizational barriers to help-seeking behaviors.
- (5) Cultivating supportive climates.
- (6) Knowing resources and making appropriate referrals when necessary.
- (7) Establishing and enforcing zero-tolerance policies toward bullying, hazing, belittling, discrimination, and other behaviors that adversely impact good order and discipline.
- (8) Educating all Soldiers, Army Civilians, and Family members about anxiety, stress, depression, Post Traumatic Stress Disorder (PTSD), and treatment.
- (9) Increasing behavioral health visibility and presence in Soldier areas.
- (10) Encouraging help from behavioral health providers that precludes treatment, similar to critical incident stress debriefings.
- (11) Reinforcing the power of the buddy system as a support system in times of crisis.
- (12) Educating leaders regarding Army policy that prohibits belittling Soldiers for seeking behavioral health care.
- (13) Normalizing healthy help-seeking behavior through an aggressive strategic communications plan.
- (14) Reinforcing Army Values.

3–5. Awareness

a. An essential foundation to the suicide prevention program is communicating key suicide prevention messages to Soldiers, leaders, Army Civilians, and Families. As a result, the following goals may be achieved:

- (1) The subject of suicide is normalized. Soldiers and Families need to feel comfortable discussing suicide and

asking those who are contemplating suicide the tough questions. Individuals need to be aware that they are not alone and do not need to suffer in isolation and silence.

(2) The seriousness of the problem is highlighted, with specific emphasis on consequences and long-lasting effects of suicide on the Family members and loved ones who are directly affected.

(3) Stigma is reduced and help-seeking behavior is encouraged.

(4) Warning signs and symptoms are more readily recognized. Individuals struggling with thoughts of suicide may be identified.

(5) The Ask, Care, Escort (ACE) model is used to intervene with someone who may be at risk of suicide.

(6) The battle buddy system is reinforced as a way to emphasize Army Values at the personal level. Soldiers are encouraged to take responsibility for their buddy.

(7) Soldiers, Army Civilians, and Family members are informed of helping resources available to them.

(8) Training opportunities and events are announced and individuals participate in local community activities.

(9) Soldier and leader responsibilities for suicide prevention in the Army are emphasized.

(10) Involvement in resiliency-building activities is encouraged to promote well-being for the whole Soldier, Army Civilian, and Family members' physical, emotional, behavioral, and spiritual well-being.

b. Awareness communication can take many forms. A large selection of materials is available through the U.S. Army Public Health Command (USAPHC) and the Suicide Prevention Resource Center.

c. Commanders at all levels may wish to produce their own materials, especially for inclusion in unit newsletters or newspapers. It is important to coordinate with subject matter experts, installation SPPM, public affairs offices, and local community health services for accuracy and appropriateness of content of the information in unit newsletters. Media items may be published prior to periods or events that are likely to produce a higher than normal incident of suicide (for example, the summer moving months of July and August have a higher incidence of suicide).

d. Printed media may include posters, brochures, tip cards, command newsletters and/or newspapers, and magazines. Briefings, trainings, stand downs, chain teachings, and command messages given during formations are great ways for leaders to communicate key suicide prevention messages. Other methods include static displays, films, day/week/month observances, media events, opportunities to participate in local events, and strategic communication plans.

e. The Army routinely observes Suicide Prevention Month in conjunction with the National Suicide Prevention Week and the World Suicide Prevention Day. The Army usually observes Suicide Prevention Month in the same month in which the national observance falls (September). This ensures that all Soldiers are able to participate throughout the Army Force Generation cycle.

3-6. Strategic communication plan

A strategic communication plan is designed to increase awareness regarding programs, training, and resources available to assist in suicide prevention and building resilience. Every effort should be made to decrease the stigma associated with seeking behavioral health treatment, thereby reducing suicides and suicidal behaviors. The SPTF and/or CHPC should work with the local public affairs office to develop and distribute a yearly strategic communication plan which includes the following elements:

a. A standardized marketing program that creates awareness of the existence, nature, and availability of all Army health promotion, risk reduction and suicide prevention products and services. This includes standardized delivery of resultant communications and metrics to measure awareness of products and services by Soldiers, Army Civilians, and their Families.

b. A cohesive, coordinated effort to build and maintain a continuum of awareness at the local level, in conjunction with prescribed training and awareness that should be updated on at least an annual basis and at a minimum contain the following points:

(1) Purpose and/or issue.

(2) Public and/or command information (theme).

(3) Engagement strategy.

(4) Strategic context.

(5) Overarching theme and/or overarching messages.

(6) Key talking points.

(7) Desired effects.

c. The use of public service-type announcements and/or commercials using leaders and/or celebrities with a message encouraging help-seeking behaviors and suicide intervention practices.

d. Publication and promotion of existing military and civilian crisis hot line numbers in local media and resource materials.

e. Publication and internet availability of articles on stress, depression, Family violence and abuse, substance abuse, and the identification of agencies that can help.

f. Publication and dissemination of a list of online resources for information and support.

g. Tailored community awareness activities that have been evaluated by the SPTF.

- h.* Annual Armywide guidance and recommended activities for observance of Suicide Prevention Month.
- i.* Formally scheduled, regular health promotion, risk reduction, and suicide prevention observances and/or activities.
- j.* Clear and consistent key messages that include the following:
 - (1) Suicide prevention is critical in the Army.
 - (2) Suicide prevention is about Soldiers taking care of Soldiers. In the Army, Soldiers always take care of battle buddies.
 - (3) Seeking help is a sign of strength.
 - (4) Consistent messaging to support the theme: “Need Help-Seek Help, Treatment Works.”
 - (5) Leadership involvement is paramount.
 - (6) Taking care of “our own” is part of the Army culture and ethos.
 - (7) Suicide affects the Total Force (Soldiers, Army Civilians and Family members) and requires a Total Force commitment to defeat.
 - (8) The Army is committed to decreasing stigma, improving access to care, and incorporating suicide prevention and resiliency training into all training programs.
 - (9) World class training and resources are available to assist Soldiers, Army Civilians and Family members.
 - (10) Any loss is a tragedy regardless of the reason.
 - (11) The goal is to provide Soldiers, Army Civilians and Family members the best available support to overcome stressors.

Chapter 4 Intervention

4-1. Suicide intervention

- a.* Intervention attempts to prevent a life crisis or behavioral disorder from leading to suicidal behavior, and includes managing suicidal thoughts that may arise. At its most basic level, intervention may simply include listening, showing empathy, and escorting a person to a helping agency. This is something that can be done by any Soldiers, Army Civilians, and Family members with minimal training at the unit level. Army-approved training for this level includes suicide prevention training (ACE) programs for Soldiers, leaders, Army Civilians, and Families.
- b.* Intervention may also include the use of more advanced skills by trained personnel who are capable of providing a greater level of crisis intervention, screening, care, and referral. All company-level junior leaders and first-line supervisors may receive training in intervention that enhances skills, knowledge, and confidence to intervene in a crisis. This training can take many forms, from specified suicide intervention training to broader crisis intervention training. The approved Army program for suicide intervention training is the 4-hour ACE–Suicide Intervention (SI) training.
- c.* An even greater level of intervention is provided by formally trained gatekeepers. Primary gatekeepers can be chaplains, FAP workers, and health care personnel whose primary duties involve assisting people who are more susceptible to suicidal ideation. Secondary gatekeepers are personnel who, by the nature of their job, may come in contact with a person at risk. These can include law enforcement, inspectors general, and Red Cross staff members.

4-2. Risk factors and warning signs

Individuals who are frequently in close contact with others are often in the best position to identify persons at risk if they know the risk factors and warning signs. Individuals can include leaders, Family members, buddies, close friends, and coworkers. Recognition of risk factors and warning signs is a common part of awareness and intervention training.

- a.* Certain factors increase an individual’s risk for suicide. Some risk factors include the following:
 - (1) Failed intimate relationship or relationship strain.
 - (2) Previous suicide attempts.
 - (3) Family history of suicide, suicide attempts, depression, or other psychiatric illness.
 - (4) Depression and/or history of PTSD or other behavioral health illness.
 - (5) Significant loss (death of loved one, loss due to natural disasters, and so on).
 - (6) Poor social skills, to include difficulty interacting with others (social isolation).
 - (7) Drug or alcohol abuse.
 - (8) Violence in the home or social environment.
 - (9) Access to means of suicide (particularly, handguns in the home).
 - (10) Current and/or pending disciplinary or legal actions (Article 15, UCMJ).
 - (11) Serious medical problems or physical illness.
 - (12) Work-related problems.
 - (13) Excessive debt.
 - (14) Severe, prolonged, and/or perceived unmanageable stress.

- (15) Setbacks (academic, career or personal).
- (16) Transitions (retirement, PCS, discharge, and so on).
- (17) Sense of powerlessness, helplessness, and/or hopelessness.
- (18) Loss of employment (reserve component).

b. While some suicides occur without any obvious warning, most individuals considering suicide do give warning signs. Warning signs of suicide include the following:

- (1) Noticeable changes in eating and/or sleeping habits and personal hygiene.
- (2) Talking and/or hinting about suicide, expressing a strong wish to die, or a desire to kill someone else.
- (3) Obsession with death (for example, in music, poetry, or artwork).
- (4) Change in mood (for example, depression, irritability, rage, or anger).
- (5) Isolation and withdrawal from social situations. Increased alcohol and/or drug use or abuse.
- (6) Giving away possessions or disregard for what happens to possessions and/or suddenly making a will.
- (7) Feeling sad, depressed, hopeless, anxious, psychic pain, or inner tension.
- (8) Finalizing personal affairs.
- (9) Themes of death in letters and notes.
- (10) Problems with girlfriend or boyfriend or spouse.
- (11) Experiencing financial problems or in trouble for misconduct.

(12) Sudden or impulsive purchase of a firearm or obtaining other means of committing suicide, such as poisons or medications.

4-3. Confidential services

Widespread promotion of suicide prevention and general crisis hotlines provides a confidential means for Soldiers, Army Civilians, and Family members to reach out for help in a non-threatening way. The National Suicide Prevention Lifeline, 1-800-273-TALK and Military Crisis Line, "1-800-273-8255, press 1," offer free, confidential, 24-hour access services, 365 days per year to assist members in crisis or concerned friends and families.

4-4. Prevention and Intervention screening

a. Screening is an important part of prevention and intervention. Since areas such as sexual assault, substance abuse, domestic violence, depression, and PTSD are significant contributors to suicidal ideation, collaboration with subject matter experts in these fields is crucial, especially when screening Soldiers. Screening can be done in person, online, or made available as a self-assessment. These can be used to target specific populations that may be at higher risk due to recent crisis events or as a matter of routine before, during, and after times of expected higher stress. It is important that all screening includes referral to appropriate resources and, where possible, a tracking mechanism for follow-up of high-risk individuals. Other effective screening tools target the pre and post deployment periods which historically are times of high stress.

b. The DD Form 2795 (Pre-Deployment Health Assessment) is completed 120 days prior to deployment and validated within 60 days of deployment. The DD Form 2796 (Post-Deployment Health Assessment (PDHA)) is normally completed at the demobilization station, not to exceed 30 days after re-deployment. The DD Form 2900 (Post-Deployment Health Re-Assessment (PDHRA)) is completed 90 to 180 days after that, during the 3- to 6-month time period after return from deployment (ideally at the 3- to 4-month mark). The re-assessment is scheduled for completion before the end of 180 days after return so that Reserve Component members have the option of treatment using their TRICARE health benefit. These are completed and involve a face to face session with referrals where necessary. Leaders should support Soldiers and Army Civilians by providing encouragement to follow through with referrals, coordinating transportation and time off during the duty day, and helping identify appropriate resources.

(1) Assessments for people entering programs such as Substance Abuse Counseling, Child and Family Services, Domestic Violence, Social Work Services, and behavioral health should include questions to help assess for risk of suicide.

(2) Self-screening is available through various sites on the internet to help assess for depression, bipolar disorder, anxiety disorders, post traumatic stress, suicide, and other issues. This information is available at <http://mental-healthscreening.org/military> a site sponsored by DOD through the Military Pathways (<http://www.pdhealth.mil/militarypathways.asp>). Most Web sites provide recommendations and referral, and some may even connect at-risk individuals directly with helping professionals.

4-5. Ask, Care, Escort suicide prevention training

ACE is the Army-approved model for suicide prevention and awareness training and provides an easy to remember acronym that any Soldier, leader, Army Civilian, or Family member can use. Training modules are located on the Army Suicide Prevention Web site (<http://www.preventsuicide.army.mil>). These include training modules for suicide prevention for Soldiers, leaders, Army Civilians, and Family members and ACE-Suicide Intervention (ACE-SI) training. Other products reinforce the use of ACE, to include Beyond The Front and The Home Front interactive video simulations and the Shoulder to Shoulder video series.

a. Ask.

(1) Ask your battle buddy directly about thoughts or plans for suicide. Take threats seriously. Trust suspicions, as some warning signs may be subtle. Do not ignore cries for help.

(2) Confront the problem directly. Ask the question and stay calm (for example, “Are you thinking of killing yourself?” “Do you want to die?” “Do you wish you were dead?” “Have you thought of how you would kill yourself?”).

(3) Talk openly about suicide. Do not be afraid to discuss suicide with the person. Be willing to listen and allow the person to express feelings. Do not make moral judgments, act shocked, or make light of the situation. Do not try to minimize the problem. Trying to convince a person it is not that bad or they have everything to live for may only increase their feelings of guilt and hopelessness.

b. Care.

(1) Care for your battle buddy by understanding that your battle buddy may be in pain. Persons who attempt suicide most often feel alone, worthless, and unloved. Help by letting them know that they are not alone; listen when they are ready to talk. Provide a lifeline by assuring the person that help is available. By assuring the person that help is available, you are throwing them a lifeline.

(2) Remove any means that could be used for self-injury.

(3) Active listening may produce relief.

(4) Calmly control the situation; do not use force.

(5) Encourage the person to seek help voluntarily. Do not force the person.

(6) Reassure the person that help is available, depression is treatable, and that suicidal feelings are normally temporary.

c. Escort.

(1) Escort your battle buddy immediately to a helping person or provider (emergency room, chain of command, chaplain, behavioral health professional, or primary care provider).

(2) Never leave the person alone. Emergency rooms and urgent care rooms are the primary 24-hour crisis intervention facilities. Sometimes it is necessary to refer directly to the person’s primary care manager to get a referral to a behavioral health provider.

(3) Never try to force someone to get help. Law enforcement and medical personnel should be summoned to the scene if the individual declines assistance.

d. Training qualifications. There are no specific qualifications required to conduct ACE training. Commanders may select key personnel to serve as ACE trainers for their organizations. ACE–SI trainers are also selected by commanders and are certified by attending training workshops conducted by DCS, G–1 (ASPP). These individuals may be military or Army Civilians and are qualified to conduct ACE–SI workshops. These individuals are also ideally suited to conduct ACE training for their assigned organizations.

(1) The ASPP coordinates train-the-trainer ACE–SI training workshops to selected regional personnel to support local efforts in maintaining ACE certified facilitators.

(2) Standardized qualifications for other suicide intervention skills training is provided by the DCS, G–1, as required.

4–6. Unit Watch

Unit Watch is a commanders’ program that is designed and implemented to protect at-risk Soldiers from self-harm and harm to others (see Department of Defense Instruction (DODI) 6490.04). The Unit Watch program requires—

a. Positive control of the Soldier, especially during periods of transition from unit events to other appointments.

b. Soldiers under watch are escorted at all times, and not left alone or unsupervised.

c. That those entrusted to conduct Unit Watch are thoroughly briefed on the importance of being with the Soldier at all times.

d. While in Unit Watch status, the Soldier receives close follow-up by behavioral health.

e. That no unnecessary measures are enacted which bring undue attention, shame, or humiliation upon the Soldier.

f. Special considerations.

4–7. Additional considerations

a. For Soldiers pending UCMJ action, commanders, military law enforcement, and The Judge Advocate should develop procedures to mitigate risk factors during investigations, adjudication, and other adverse actions. Soldiers pending UCMJ become high risk and they should be supported during and after proceedings.

b. An encounter with an at-risk person can be a deeply emotional experience, especially when someone is not trained to provide assistance or has limited experience with people in crisis. In these situations, it is important to process the experience with someone trained and knowledgeable.

c. Although a person may think he or she wants to die, he or she has an innate will to live, and is more likely

hoping to be rescued. Probing for ambivalence can be an effective way to break through the desire to die and convince someone to get help voluntarily.

d. Care should be taken when referring both active duty and non-active duty Soldiers to civilian resources. This could set them up for increased financial stress due to medical bills they may not have resources to cover. Caution should be exercised to ensure that Soldiers do not incur a financial hardship from a referral action.

e. Leaders play an important role in ensuring the crisis has been mitigated and that conditions which produced the current crisis have been addressed. HCPs may provide treatment to reduce ideation and behavior, but it is the first-line supervisors that are in the best position to work with the Soldier to resolve situational issues and develop strategies to prevent them from developing to crisis level again. Leaders should be careful to not presume a threat has passed simply because there are no immediate concerns.

f. Use of social networking technologies are popular means used today to communicate important personal information. Although these sites are not normally authorized access for Government computers, when available they can be great resources for information on the well-being of Soldiers. Leaders can stay tuned to the personal lives of Soldiers and their Families, to include identifying warning signs that someone may be in crisis. Leveraging these types of generational communication may help to accelerate identification and response time to prevent suicide.

Chapter 5

Postvention

5-1. General

Postvention consists of a sequence of planned support and interventions carried out with survivors in the aftermath of a completed suicide or suicide attempt. Postvention is prevention for survivors. The goal of suicide postvention is to support those affected by a suicide or attempt, promote healthy recovery, reduce the possibility of suicide contagion, strengthen unit cohesion, and promote continued mission readiness. The loss of a Family member, especially the loss of a child due to suicide, is perhaps the most difficult form of death for survivors to accept. On top of their grief over the death of a loved one, Families of suicide victims often experience shame, humiliation, and embarrassment. Other common reactions are fear, denial, anger, and guilt, all of which combine to produce one of the most difficult crises a Family may ever experience. At these times the complete resources of the military community should be mobilized to assist the Family.

a. When implementing a postvention program, commanders should do the following:

(1) Provide long-term support to Families, unit members, and coworkers who experience loss due to suicide. Care can be provided via external services and outreach programs, including civilian services for grief and recovery (that is, Department of Veterans Affairs Bereavement Counseling, Survivor Outreach Services, and so forth).

(2) Participate with the Casualty Assistance Officer to meet and talk with the immediate Family.

(3) Request support of the SRT to assist in coordinating and leveraging support and services.

b. Postvention activities include unit-level interventions following an attempted or completed suicide in order to minimize psychological reactions to the event, prevent or minimize the potential for copy cat suicides, strengthen unit cohesion, and promote continued mission readiness. Postvention activities may include the following:

(1) Provide care for a Soldier who has expressed suicide ideation or has attempted suicide. Commanders should ensure that Soldiers receive help navigating the health care and/or behavioral health care system to receive appropriate care. Consider the following resources when assisting Soldiers: Veterans Administration (VA), Military OneSource, chaplains, crisis hotline contact numbers, behavioral health staff members, and ASAP staff members.

(2) Provide care to the Family of those individuals who have attempted or completed suicide. Ensure Family members stay connected to a support system. Department of Veterans Affairs Bereavement Counseling is now being offered to parents, spouses, and children of Armed Forces personnel who died in the service of their country. Also eligible are Family members of Reservists and National Guardsmen who die while on duty.

(3) Provide care to the friends of someone who has attempted or completed suicide. The command should proactively address the situation and provide an outlet for those affected to express and process their emotions. Ensure each Soldier in the unit is notified of a death. Have a chaplain or behavioral health provider available to address the Soldiers as a group and be available to Soldiers who need to talk further. Specifically identify Soldiers who were close to the deceased and have an appropriate person in their chain of command offer support. In the aftermath of a suicide, promote the idea that the outcome of a crisis need not be suicide. There are other alternatives.

(4) Educate leaders on the importance of the buddy system.

(5) Honor the Soldier and support the disposition of remains. Funeral honors are an important part of the healing process for fellow Soldiers of the deceased and Family members.

(6) Collect and communicate suicide data for lessons learned, trend analysis, and to enhance quality of care.

5-2. Army suicide behavior surveillance

Army suicide behavior surveillance is a critical postvention activity which includes the collection of informational data about suicide behavior by all components. In collaboration with Office of the Deputy Chief of Staff, G-1, ASPP, the USAPHC analyzes informational data about suicide behavior in order to provide an ongoing statistical understanding about the problem, identify behavioral health trends, and formulate lessons learned. ASPP develops strategies to distribute lessons learned back down to commanders in a timely manner. The Department of Defense Suicide Event Report (DODSER) process is the DOD solution for monitoring suicides for all branches of the military. The DODSER process was developed to examine the causes and circumstances of suicide behaviors among military personnel. The DD Form 2996 (Department of Defense Suicide Event Report) standardizes the data collected on all suicide events and is an integral part of the ASPP. The DD Form 2996 should be completed for all suicides, suicide attempts, and suicidal ideations which result in hospitalizations. This includes evacuations from theater where the injury or injurious intent is self-directed.

a. The administrative responsibility for the DODSER program resides within USAPHC and functions under the direction of a project manager. The DODSER project manager functions within the Behavioral and Social Outcomes Program DODSER cell, which is located within USAPHC's Institute of Public Health Epidemiology and Disease portfolio. The DODSER project manager, with the assistance of the DODSER data manager, is responsible for monitoring both the timeliness and quality of the DD Form 2996s submitted to the DODSER database.

b. Administrative operations shared by the project and data managers include downloading DD Form 2996s to the Army Behavioral Health Integrated Data Environment; responding to ad hoc requests for information from installations; completing quarterly quality assurance on submitted DD Form 2996s; developing routine quarterly reports; tracking completed and delinquent DD Form 2996s; providing DODSER site support; completing transfers on required DD Form 2996s; resolving duplicate DD Form 2996s; training assistance; submitting annual improvement recommendations to Defense Center of Excellence/Telehealth and Technology; and assisting in obtaining information for DD Form 2996 completions (for example, AR 15-6 reports, DA Form 7747, and others).

c. For suicides, formal requests to complete the DD Form 2996 are sent by the DODSER data manager to the medical treatment facility DODSER point of contact for each Armed Forces Medical Examiner confirmed event; follow-up messages are sent for all events for which a DD Form 2996 is not received in the required 60 days of the suicide or within 30 days of an identified hospitalization for suicidal ideation or attempt.

d. In the continental United States, each medical treatment facility commander designates and appoints on orders a behavioral health professional to serve as the medical treatment facility DODSER point of contact for at least 1 year. If outside the continental United States (ACOM, ASCC, and in forward-deployed theaters of operation), the senior medical commander appoints on orders a behavioral health officer to serve as the DODSER point of contact. For DD Form 2996s on Reserve Component Soldiers, completion is assigned to the nearest medical treatment facility at which the Soldier's unit of assignment receives medical care. The point of contact ensures that the completed DD Form 2996 is submitted via a secure Web site: <https://DODSER.t2.health.mil/>.

e. In the event a Soldier is admitted to a civilian hospital for serious suicidal ideation or a suicide attempt, the unit commander is responsible for notifying the supporting medical treatment facility clinical operations cell during daytime work hours and the administrative officer of the day during non-duty hours to inform the leadership of the Soldier's name, rank, social security number, and whether the Soldier was admitted for a suicide attempt or ideation. Prior to the submission of a completed DD Form 2996 the MTF commander or the senior theater medical commander co-signs with the Brigade commander or equivalent commander indicating that the information in the DD Form 2996 is correct.

f. In collaboration with the medical treatment facility commander, the Chief, Behavioral Health Services and the Community Health Promotion Council (CHPC) monitor the completion of the DD Form 2996. Feedback from the DD Form 2996 quality assurance review is provided by USAPHC to medical treatment facility commanders annually or upon formal request. Compliance reports that highlight delinquent DD Form 2996s are issued to medical treatment facility DODSER points of contact.

g. In conjunction with ASPP, data from the preceding investigations and information-gathering systems is collected and maintained by USAPHC. The USAPHC routinely assess the data for all components on a regular basis to provide statistical understanding, identify trends, formulate lessons learned, and develop recommendations.

h. Medical Command provides and grants USAPHC personnel access to beneficiary medical records, to include automated systems, to facilitate suicide surveillance and reporting requirements.

i. DCS, G-1 develops strategies to distribute trends and lessons learned back down to commanders in a timely manner. All components provide input to the DODSER database in accordance with protocols established by ASPP and USAPHC.

j. The DD Form 2996, as a reporting tool, is not intended to replace the psychological autopsy, which is limited to fatalities in which the manner of death is uncertain.

k. Psychological autopsies may be requested by the Armed Forces Medical Examiner and/or CID on active duty deaths under special circumstances, in accordance with AR 600-63. Additionally, the senior commander may instead, request a behavioral analysis review through CID. The psychological autopsy is a forensic investigative tool that is used to confirm or refute the death of an individual by suicide. It is not to be confused with gathering of information

for suicide event surveillance for epidemiological purposes. Specifically, psychological autopsies assist in ascertaining the manner of death, and are primarily used to resolve cases where there is an equivocal cause of death; that is, death cannot be readily established as natural, accidental, a suicide, or a homicide. Some examples might include a single vehicle accident, or incidents involving unusual or suspicious circumstances, such as deaths due to substance abuse or resulting from apparently unintentional, self-inflicted gunshot wounds. Subjects for investigation include all Active Army Soldiers and any active member of other Armed Forces of the United States assigned or attached to an Army unit or installation. (See app B for an example of behavioral analysis review questions and/or categories.)

l. For all completed and attempted suicides:

(1) Ensure the disclosure of medical information to non-medical entities conforms to confidentiality laws and appropriate protocols for information sharing are followed. The type and amount of information disclosed is based on Health Insurance Portability and Accountability Act (HIPAA) confidentiality laws.

(2) Ensure appropriate protocols for information sharing are followed.

(3) Ensure the quality improvement and/or quality assessment program performs root cause analysis on all deaths that occur within 31 days of last scheduled medical appointment.

(4) Interface with local law enforcement, coroners, and medical examiners to document the death determination and to collect epidemiological data regarding off-post suspected suicides of Reserve Component Soldiers.

(5) Ensure that an AR 15-6 investigation is completed for all suicides and suspected suicides in accordance with Army Directive 2010-1.

m. Other investigative activities for the postvention process include:

(1) CID investigates all non-combat deaths, in accordance with AR 195-2 and DODI 5505.10. For off post deaths, CID has limited legal authority to conduct investigations, but can leverage professional relationships with local authorities where appropriate under the guidelines of AR 195-2 to support local commanders in obtaining police reports, coroner's reports, and death certificates.

(2) A line of duty is conducted on all deaths of Soldiers who, at the time of death, were on active duty, in an IDT status, or where the death is suspected to be connected to a previous duty incident. The line of duty is conducted in accordance with AR 600-8-4. (See AR 600-63 and AR 600-8-24, para 4-13.)

Chapter 6

Geographically-Dispersed Soldiers

6-1. Geographically-dispersed Soldiers

Geographically-dispersed Soldiers are defined as those who do not live within the 50-mile radius catchment area of a military installation. Geographically-dispersed Soldiers and their Families have challenges to access services related to health promotion, risk reduction, and suicide prevention. Active duty Soldiers and their Families who cannot easily access an installation are in danger of becoming isolated from critical support services normally available to them. Lack of entitlements for USAR and ARNG Soldiers limits access to many services readily available to the active force. It is important for commands of geographically-dispersed Soldiers to implement strategies to leverage noninstallation-based services available at the national, state, and local levels to ensure Soldiers have appropriate support regardless of their location. Some of these resources are as follows:

a. Tri-service medical care remote. Soldiers on active duty orders for more than 30 days, and their Families, can utilize benefits at approved local clinics. Information can be found at <http://www.tricare.mil>. Respective TRICARE representatives can clarify benefits and help locate appropriate services.

b. Memorandums of agreement. Many state and county behavioral health organizations can provide services to Soldiers and their Families free of charge or on a sliding fee scale through memorandums of agreement established with state JFHQs.

c. Military OneSource. Specifically geared to serve geographically-dispersed Soldiers and Families, Military OneSource, at www.militaryonesource.mil, provides resources and support 24 hours a day, 7 days a week, on a wide variety of subjects. Among available services are consultations on child care and relocation, translation services in more than 140 languages, up to 12 professional counseling sessions, educational materials, and Web-based interactive media. Services are provided by DOD at no cost to all Soldiers (Active Army, ARNG, and USAR) and their Families.

d. Family Assistance Centers. There are more than 380 Family Assistance Centers hosted by the ARNG. They are strategically placed in local communities in every state for use by military members and their Families, regardless of Service or component. Families can find the Family Assistance Center closest to them by accessing <http://www.myarmyonesource.com> and clicking on "Family Programs and Services" (on the left side of the screen), then "Family Programs," and then "Soldier Family Assistance Center." In addition, Warrior Family Assistance Centers support USAR Soldiers and Families. Information can be obtained at www.arfp.org/wfac.

e. Non-profit organizations. Several national non-profit organizations reach out to communities nationwide on behalf of Soldiers and their Families.

f. Online resources. These resources provide another avenue to reach geographically-dispersed Soldiers and their Families. Web-based services that support health promotion, risk reduction, and suicide prevention are accessible from any geographical location with a Web connection. A partial list of important Web sites is in appendix D of this document.

6–2. Case management for Reserve Component high-risk Soldiers

Case management for high-risk Soldiers in the Reserve Components is available in many instances by the State Director of Psychological Health.

6–3. Collaboration

a. Active, Guard, and Reserve Components should collaborate in order to take care of Soldiers and Families in geographically remote areas. Active Army recruiters may be located far from installation-based services and yet be within easy reach of services available to Reserve Component Soldiers. The opposite may also be true.

b. Just as the USAR is regionally-based and the ARNG is state-based, so also are many of the community services that would benefit Soldiers. The USAR and the ARNG should work together to leverage these resources. The ACOMs, ASCCs, and DRUs work to harness regionally-based services that would be available to all components, and the state JFHQs can, in return, do the same for state-based services. Developing memorandums of agreement to expand availability of services across components ensures maximum coverage for all Soldiers.

6–4. National, state, and local support

a. There are many national, state, and local services available for geographically-dispersed Soldiers and their Families. The SPTFs should develop a well thought out and deliberate strategic communications plan to communicate important suicide prevention messages and provide listings of available services and how to access them.

b. The geographically-dispersed live outside of exposure to installation-based mass media campaigns. To effectively reach them, communication should be through means relevant to the location and situation of the target audience. Communication channels may include email, unit newsletters, mass mailings, armory bulletin boards, command letters, organizational Web sites, and printed media.

c. A list of available prevention, intervention, and postvention resources can be found in appendix D.

6–5. Suicide incident reporting

There are challenges in suicide incident reporting for geographically-dispersed Soldiers, especially those in the Reserve Components. State and local ordinances vary regarding release of police reports, coroner's reports, and vital statistical records such as death certificates. These ordinances can be very restrictive and have the potential to limit the Army's ability to gather data and confirm means of death. Confusion on applying HIPAA and privacy laws also can restrict information gathering. Implementing the following strategies can help to alleviate some of these situations.

a. The SPTF should create memoranda of agreement with local authorities for sharing of documents and information when a Soldier dies.

b. Acquire death certificates from the military personnel office which processes Soldier Group Life Insurance claims for survivors.

c. Integrate a representative into suicide prevention and behavioral health councils to build and leverage professional contacts.

d. Initiate a relationship with the state coroner's office to solicit aid in acquiring documentation.

e. Solicit help from CID to serve as liaison with local authorities to obtain documentation.

Chapter 7 Deployment

7–1. Introduction

a. When Soldiers and Army Civilians are deployed, it is vital that continental United States-based suicide prevention program efforts are continued so that complete coverage can be maintained from garrison to theater and back to garrison.

b. Deployment can cause unique stress for Soldiers and Army Civilians and, therefore, requires due vigilance on the part of the command to ensure the health and safety of all assigned personnel. During challenging missions in austere environments, the state of behavioral health of the individual Soldier and Army Civilian may unintentionally get overlooked. Considerable effort should be made to maintain care and treatment for at-risk personnel.

7–2. Deployment cycle support

a. The deployment cycle support requirements established by DCS, G–1 mandate suicide prevention training for all three stages of the deployment cycle per Army Directive 2012–13 (Policy and Implementing Guidance for Deployment

Cycle Support). Deployment cycle support is aligned to mirror the three Army Force Generation phases of RESET, Train/Ready, and Available. These requirements include suicide prevention training for Soldiers, Army Civilians, leaders and gatekeepers. Commanders are encouraged to increase the number of Soldiers, leaders, and Army Civilians trained in advanced intervention skills during the pre-deployment (Train/Ready) phase. This increase in personnel with intervention skills training expands the commander's ability to monitor Soldiers and Army Civilians before, during, and after periods of higher stress and exposure to combat-related events during the deployment (Available) phase when units or individuals are at installations outside the continental United States and in the designated theater. Other applicable products are the 4-hour ACE-SI training and the suicide intervention skills training as approved by the DCS, G-1.

b. During deployment, periods of high susceptibility for suicide may be around mid-term leave, periods of rest and relaxation leave, or emergency leave. It is important that Soldiers and Army Civilians are presented with suicide prevention training in anticipation of and upon return from these leave periods. It would also be beneficial for leaders to interview Soldiers and Army Civilians regarding expectations, problems back home, and any anticipated stressors they may face during a particular period of leave. This interview time could provide opportunities for intervention to mitigate risk to the Soldier and Army Civilian. It also helps to highlight issues for the command to monitor upon their return and subsequent re-integration into the pre-deployment environment during the RESET phase.

7-3. Family support during the deployment cycle support process

a. Families are just as susceptible as Soldiers to higher levels of stress during deployment. Each phase of the deployment cycle presents its own unique stressors. Deployment cycle support is a comprehensive process that ensures that Soldiers, Army Civilians, and their Families are better prepared and sustained throughout the deployment cycle. Services for Army Civilians and Families are integrated in every stage of the process and they are highly encouraged to take advantage of available resources.

b. Operation READY Pre-Deployment Resilience Training (formerly known as Battlemind Training) for Spouses and an accompanying brochure are provided during the Ready phase of deployment cycle support. Also, Operation READY Post-Deployment Resilience Training for Spouses, and Operation READY Reunion and Re-integration Training are provided to Families of redeploying Soldiers and Army Civilians during the RESET phase of deployment cycle support.

c. Although no formal requirements have been established to train Family members in suicide prevention during the deployment cycle, it is important to equip them with the skills to recognize the warning signs, seek help for themselves, and to intervene with a Family member. It can be beneficial to provide suicide prevention training to Families during times when they are anticipating the departure of the Soldier (Train/Ready), during the long separation (Available), and during the stressful time of re-integration (RESET). This training should address the needs of the spouse and children of married Soldiers, and the parents, boyfriends, and girlfriends of single Soldiers as appropriate.

7-4. Deployment Health Assessment Program execution during the deployment cycle

a. The Deployment Health Assessment Program (DHAP) is a DOD deployment health program (DODI 6490.03) designed to address physical and behavioral health conditions and concerns within the deployment cycle for Soldiers and Army Civilians. The DHAP is a unit commander program that supports the Army-wide effort to maximize Soldiers and Army Civilians well-being, build resilience, reduce non-deployable status and maximize readiness across all Army Components and organizations.

b. DHAP is a force multiplier when commanders make it a command priority and understand the conditions that drive execution. Those conditions include all deployments outside the continental United States (OCONUS). This includes operational deployments, training events, and humanitarian missions greater than 30 days to locations not supported by a fixed U.S. Military Treatment Facility (MTF). Moreover, commanders should also determine the environmental risks and the need for DHAP execution for all deployments of 30 days or less to any location, CONUS or OCONUS. Commanders should refer to DODI 6490.03 when making these decisions.

c. DHAP provides a comprehensive health screening prior to deployment, during deployment, and again after redeployment. The three DHAs are tailored to identify and examine emerging deployment-related physical and behavioral health concerns such as traumatic brain injury (TBI), PTSD, and other environmental exposures that could lead to more serious conditions (suicide, drug and alcohol abuse, sexual assault, and so forth). DHAP gives Soldiers and Army Civilians the opportunity to proactively identify and then— if necessary—be treated for those health concerns. DHAP consists of the following three health assessments:

(1) *Pre-Deployment Health Assessment.* Unit and installation commanders/staff schedule initial/pre-SRP activities that include the completion of the DD Form 2795 prior to 120 days from the estimated deployment date to meet the Mental Health Assessment (MHA) requirement. (See DODI 6490.12.) Conduct initial/pre-SRP events several months prior to deployment will allow commanders to identify all emerging non-deployable conditions that have a direct impact on well-being and unit operational readiness. Following the initial/pre-SRP, commanders and staff schedule a final SRP that screens and validates medical readiness in preparation for deployment. The final SRP event must occur within 60 days prior to the expected deployment date. (See DODI 6490.03.) This validation does not include the generation of a new form. The HCP reviews the DD Form 2795 self-assessment with the Soldier to identify and

address health concerns, issue referrals as needed, and validate individual medical readiness prior to deployment. Once the assessment is completed, the DD Form 2795 is signed by the HCP.

(2) *Post-Deployment Health Assessment.* The DD Form 2796 is taken within +/- 30 days after redeployment. The DD Form 2796 can be performed prior to theater departure, but must be reviewed and validated by a HCP during post deployment SRP medical activities upon arrival at home station or demobilization station.

(3) *Post-Deployment Health Re-Assessment.* The DD Form 2900 is taken 90–180 days after redeployment. (See DODI 6490.03.) Medical studies show that the 90- to 180-day window of execution is critical to identifying emerging conditions that have a direct impact on health and well-being, and unit operational readiness. Commanders and staff must include the DD Form 2900 within the post-deployment training calendar to ensure execution and maximum participation.

(4) *Periodic Health Assessment.* If a Soldier's Periodic Health Assessment (PHA) is more than 12 months old or will expire during their deployment, a PHA should be conducted during the DD Form 2795 process. (See AR 40–501.)

d. Each PHA is supported by a specific resilience training requirement (mandatory for Soldiers and strongly recommended for Army Civilians) designed to promote honest participation in the health assessment process during the initial self-assessment process and follow-on confidential (one-on-one) conversation with a health care provider.

Chapter 8

Family Member Suicide Prevention

8–1. Introduction

Family member suicide prevention program is based on existing military and civilian Family and social service resources as well as new and innovative programs. Family members, as defined by Defense Eligibility Enrollment Reporting System, are entitled to, and receive, the same services and treatment as their military sponsor. Among these resources are chaplains and chaplain assistants, behavioral and behavioral health specialists, substance abuse counselors, social workers, and TRICARE services. Subject matter experts in various disciplines and organizations provide suicide prevention support. Family members may seek help independently or use their sponsor's chain of command to initiate their request for suicide prevention services and for assistance at any point during the period of need.

8–2. Education awareness services

Education awareness information and/or services are available from any of the following:

a. Military OneSource is DOD's one-stop, Web-based resource for Servicemembers or Family members at <http://www.militaryonesource.com>. Military OneSource connects users around the world to Service-specific support through a central portal available 24 hours a day. Military OneSource is an internet Web-based service that includes up to 12 face-to-face, Web-based or telephonic counseling sessions. Military OneSource consultants are professionally qualified with a minimum of a Master's degree in social work or a counseling discipline. Military OneSource provides referrals to professional civilian counselors for assistance in the continental United States, including Alaska, Hawaii, Puerto Rico, and the U.S. Virgin Islands. Outside the continental United States, face-to-face counseling is provided via existing medical treatment facility services. Services are available on-demand in more than 140 languages.

b. Army OneSource can be reached through Military OneSource, or directly at <http://www.myArmyOneSource.com>. It is a service designed to provide round-the-clock information and referrals to Soldiers and their immediate Families, as well as to deployed Army Civilians and their Families. Through the Web site, Army OneSource can provide information on the closest military resource for services regardless of geographic location or Army component. Army OneSource ensures that a standard of baseline services are provided to all Soldiers and Family members wherever they are located. Information and services that are available to all Army components include referral to counseling services, childcare referrals, financial assistance, and referral to TRICARE services.

c. The ACS FAP helps strengthen Family relationships through education and prevention tactics. The program is dedicated to enhancing individual coping skills and alleviating the underlying causes of unhealthy stress associated with Family violence. FAP provides prevention education services to restore and maintain healthy relationships, while respecting customer confidentiality. ACS assists with referrals for additional support, as needed.

d. Other resources include MFLCs as clinical providers, chaplains, ASAP (AR 600–85), and local law enforcement authorities.

8–3. Family life support

Family support services and education can be accessed through the sponsor's chain of command or any of the following:

a. MFLCs program. MFLCs are licensed clinical providers who provide counseling services to address issues that occur across the military life cycle and help Servicemembers and their Families cope with normal reactions to the stressful and/or adverse situations created by deployments and re-integration. The MFLC program provides anonymous, confidential, situational, short-term, non-medical, problem-solving counseling to all Army component members and

their Families, to augment existing military support programs. Soldiers and Family members are entitled to 12 face-to-face sessions at no cost. MFLCs are licensed clinicians with a Masters Degree or Doctor of Philosophy and at least 5 years experience in social work, counseling, or a related clinical discipline. Consultants are trained on military-specific topics including a basic orientation to the deployment cycle, military culture, and the chain of command.

b. MFLCs assist Servicemembers and their Families with issues they may face through the cycle of deployment - from leaving their loved ones and possibly living and working in harm's way, to re-integrating with the community and Family. MFLCs provide support for a range of issues including relationships, crisis intervention, stress management, grief, victim support services, psycho-education, occupational, and other individual and Family issues. Psycho-educational presentations on reunion and/or re-integration, stress and/or coping, grief and/or loss, and deployment are given to commands, Family Readiness Groups, and Soldier Readiness Processing activities. MFLC support is also provided through child, youth, and school services.

c. MFLCs deliver counseling services in flexible formats to meet the diverse needs of the military community. Services can be delivered onsite, telephonically, or online. Mobile services are routinely delivered throughout the United States. Units that return from deployment may request MFLCs through ACS.

d. Other Family support training resources include:

- (1) Child development and parenting classes.
- (2) Communication skills workshops.
- (3) Assertiveness training.
- (4) Stress management training.
- (5) Financial management assistance.

8-4. Chaplain support

Religious support and care are available through any Army chaplain. Chaplains provide Family Life Ministry to Soldiers and Family Members to establish and maintain personal and spiritual health, and build or restore healthy relationships. In addition, Family Life Chaplains are formally trained as pastoral counselors to support Soldiers and Family members, and to assist in facilitating enrichment programs (that is, Strong Bonds). The Chaplain Corps tailors programs, like Strong Bonds, a comprehensive relationship skills training program, to care for the Army in the broadest way possible, working collaboratively with behavior health and leaders to provide the right capabilities against current and future requirements. Chaplains support the importance of Army Families and the effectiveness of their Soldiers and recognize that Soldiers with strong relationships make better Soldiers. Strong Bonds is a sharply focused prevention-oriented program available to Active Army, ARNG, and USAR Soldiers, and their Families. Strong Bonds has programs for single Soldiers, couples, and Families.

Chapter 9

Database and/or Information Sharing

9-1. Introduction

The Army routinely collects and analyzes suicide-related data on the risk factors surrounding suicidal behavior to inform the development and/or sustainment of effective strategies to reduce suicides and suicide attempts. It is important that commanders have access to this timely and accurate information in order to identify or mitigate emerging situations before they become critical. The information system regarding health promotion, risk reduction, and suicide prevention is constantly changing and all agencies should take advantage of the latest technological solutions for information transmission and dissemination, whenever possible. Responsible agents should ensure that information identified here is sent and received by the most expedient means possible (Directive Type Memorandum 07-015-Under Secretary of Defense (Personnel & Readiness) - "DOD Social Security (SSN) Reduction Plan"). The Suicide Comprehensive Database follows applicable requirements under the Privacy Act to ensure an individual's personally identifiable information is protected. The DODSER Program Manager for the Army supports the Army enterprise by collecting a DD Form 2996 on suicides involving military personnel. The DODSER Program Manager assists in the completion of an annual DODSER Report. If a commander has any questions regarding who has a need to know, he or she should contact the servicing judge advocate before sharing any information (see AR 600-63 for further clarification).

9-2. Prevention

Commanders should use information and data provided by all members of the community health promotion council to influence prevention programs. One key source of data is the RRP developed by the ASAP. Commanders should use the information and data in the RRP developed by the ASAP. The RRP incorporates data from 21 high-risk factors and is provided to commanders on a monthly basis. Commanders get a snapshot of the areas of risk in the battalion and can match that risk against total Army rates.

9-3. Intervention

a. Records-sharing. One important key to intervention in the chain of events which may mitigate risk factors associated with suicide is records-sharing, which is facilitated by standards. It is also guided by principles and priorities. The Common Operating Environment identifies those standards and the DOD Information Enterprise Architecture (IEA) Version 2.0, Vol 1 and 2 (<https://sp3.kc.army.mil/SoSEI/SOSE/COE/default.aspx> and https://www.milsuite.mil/wiki/Army_Information_Aarchitecture_AIA, CAC required) dated July 2012, coupled with the Common Operating Environment Army Information Architecture, provides the principles and priorities for information-sharing. They provide guidance in the selection and use of approved computing technologies, and standards to foster integration and interoperability based on DOD's Guidance for Implementing Net-Centric Data Sharing (DOD 8320.02-G). <https://sp3.kc.army.mil/SoSEI/SOSE/COE/default.aspx> and https://www.milsuite.mil/wiki/Army_Information_Aarchitecture_AIA

b. Continuity of records. Soldiers enrolled in behavioral health services utilize and implement in and out-processing procedures. If identified as at-risk during in and out-processing, the installation or garrison refers the Soldier immediately and ensures the Soldier is escorted to the nearest medical facility for assessment. This information should only be shared with the respective behavioral health and/or substance abuse treatment facility. Soldiers being referred will not have their medical records accompany their DA Form 7631 (Deployment Cycle Support (DCS) Checklist) in any circumstance to prevent a HIPAA violation. This ensures a verifiable exchange of information for individuals receiving care. Continuity of support services occur through such exchange of information from the losing installation to the gaining installation. If Soldiers conduct a permanent change of station while engaged in a treatment program, their behavioral health and/or substance abuse treatment information are transferred to the gaining treatment facility in accordance with AR 600-85, paragraph 14-3c(3)(b) and AR 40-66, paragraph 8-6a.

c. Accessions and separations. To integrate Soldier medical processes (administrative separations, Military OneSource, Medical Retention Board, Medical Evaluation Board, Physical Evaluation Board, disciplinary actions, Warrior Transition Unit referrals, and so on), appropriate administrators integrate relevant information to commanders and 'helping agencies' (for example, law enforcement, ACS, ASAP) who have a need to know. (See AR 600-85, information and records management.)

d. Substance abuse. The Drug and Alcohol Management Information System is used by ASAP to record all urinalysis, patient, and program management information concerning ASAP. The database consolidates all of the Army's drug and alcohol-related data. This system can be used to identify Soldiers with recent or prolonged histories of drug and alcohol abuse and failure to complete required treatment.

e. Law enforcement. Centralized Operations Police Suite and Automated Criminal Investigation and Intelligence System contain records of on-going investigations. Soldier involvement in serious illegal situations, such as driving under the influence citations and courts-martial activity, could be indicators of an impending crisis situation which might result in suicidal behavior. The ADCO and/or ASAP Manager and other individuals who provide assistance play a role in the collection and reporting of data. The ADCO and/or ASAP Manager is provided with extracts from the DA Form 3997 (Military Police Desk Blotter), on all incidents involving alcohol, drugs, or other substance abuse on a daily basis for purposes of situational awareness.

f. Family Assistance Program. The Army Central Registry is an Armywide, centralized database containing a confidential index of substantiated victim-based reported spouse and child abuse cases. Such activities are highly correlated with suicidal behavior and merit close attention from a suicide prevention standpoint. To the extent permitted by applicable law, physician assistants, nurse practitioners, social workers, physicians, dentists, nurses, and law enforcement personnel may share relevant case records in order to mitigate high-risk behavior. See AR 608-18 for more information regarding FAP.

9-4. Postvention

a. Data from the investigations and information-gathering system listed below is collected and maintained by the USAPHC suicide analysis cell in conjunction with ASPP (in accordance with AR 600-63). The suicide analysis cell vigilantly studies the data for all components on a regular basis to provide a statistical understanding, identify trends, and formulate lessons learned. The DCS, G-1 develops strategies to distribute trends and lessons learned back down to commanders in a timely manner.

b. Postvention data gathering activities include—

- (1) Psychological autopsies, as part of a forensic investigation (when appropriate).
- (2) AR 15-6 investigations. These investigations are required for any serious incident. AR 600-63 provides that commands from all components conduct AR 15-6 investigations into all suicides or suspected Soldier suicides in accordance with Army Directive 2010-1. The line of duty determinations are generally conducted whenever a Soldier acquires a disease, incurs a significant injury, or is injured under unusual circumstances.

9-5. Digital and/or electronic resources

For more information on suicide prevention, access the following Web sites:

- a.* USAPHC: <http://phc.amedd.army.mil/topics/healthyliving/bh/Pages/SuicidePreventionEducation.aspx>.
- b.* DCS, G-1: <http://www.armyg1.army.mil/hr/suicide/default.asp>.

Appendix A References

Section I Required Publications

Unless otherwise stated, all publications are available on the Army Publishing Directorate Web site at <http://www.apd.army.mil/>.

AR 195-2

Criminal Investigations Activities (Cited in paras 2-9a, 2-13j(1), 5-2m(1).)

AR 600-63

Army Health Promotion (Cited in paras 2-4, 2-11, 2-13a, 2-15, 5-2k, 5-2m(2), 9-1, 9-4a, 9-4b(2), B-1c, C-1.)

AR 600-85

The Army Substance Abuse Program (Cited in paras 2-16c, 2-16e, 8-2d, 9-3b, 9-3c.)

Army Directive 2012-13

Policy and Implementing Guidance for Deployment Cycle Support (Cited in para 7-2a.)

Section II Related Publications

A related publication is a source of additional information. The user does not have to read a related reference to understand this publication. Unless otherwise stated, all publications are available on the APD Web site at <http://www.apd.army.mil/>. Department of Defense publications are available at <http://www.dtic.mil/>.

AR 15-6

Procedures for Investigating Officers and Boards of Officers

AR 40-66

Medical Record Administration and Healthcare Documentation

AR 40-501

Standards of Medical Fitness

AR 350-1

Army Training and Leader Development

AR 600-8-1

Army Casualty Program

AR 600-8-4

Line of Duty Policy, Procedures, and Investigations

AR 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Cycle)

AR 608-1

Army Community Service

AR 608-18

The Army Family Advocacy Program

AR 930-4

Army Emergency Relief

DA Pam 600-8-101

Personnel Processing (In-, Out-, Soldier Readiness, Mobilization, and Deployment Cycle Support)

DOD 8320.02–G

Guidance for Implementing Net-Centric Data Sharing

DOD IEA

DOD Information Enterprise Architecture (IEA) (Available at <http://dodcio.defense.gov/Home/Initiatives/DIEA.aspx>.)

DODI 5154.30

Armed Forces Institute of Pathology Operations

DODI 6490.03

Deployment Health

DODI 6490.04

Mental Health Evaluations of Members of the Military Services

DODI 6490.12

Mental Health Assessments for Service Members Deployed in Connection with a Contingency Operation

FM 6–22.5

Combat and Operational Stress Control Manual for Leaders and Soldiers

Military Rules of Evidence 502(a)

General rule of privilege (Available at <http://www.defense.gov/pubs/>.)

PL 106–58

Treasury and General Government Appropriations Act, 2000 (Available at <http://www.archives.gov>.)

Rules for Military Commissions 703(d)

Employment of expert witnesses (Available at <http://www.defense.gov/pubs/>.)

UMCJ, Article 15

Commanding Officer's Non-Judicial Punishment (Available at <http://www.au.af.mil/au/awc/awcgate/ucmj.htm>.)

5 USC 552a

Records maintained on individuals (Available at <http://uscode.house.gov/>.)

Section III

Prescribed Forms

Unless otherwise indicated, DA forms are available on the APD Web site (<http://www.apd.army.mil>).

DA Form 7747

Commander's Suspected Suicide Event Report (Cited in para 2–9*d*.)

Section IV

Referenced Forms

Unless otherwise indicated, DA forms are available on the APD Web site (<http://www.apd.army.mil>), and DD forms are available on the OSD Web site (<http://www.dtic.mil/whs/directives/infomtg/forms/formsprogram.htm>).

DA Form 2028

Recommended Changes to Publications and Blank Forms

DA Form 3997

Military Police Desk Blotter

DA Form 7631

Deployment Cycle Support (DCS) Checklist

DD Form 1300

Report of Casualty

DD Form 2795

Pre-Deployment Health Assessment (This form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

DD Form 2796

Post-Deployment Health Assessment (PDHA) (This form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

DD Form 2900

Post-Deployment Health Re-Assessment (PDHRA) (This form is completed on-line in Service-specific systems. Individuals will receive instructions and gain access to the appropriate system at the time of their assessment.)

DD Form 2996

Department of Defense Suicide Event Report

**Appendix B
Behavioral Analysis Reviews****B-1. General**

a. The behavioral analysis review is a procedure for investigating a person's suicide by reconstructing what the person thought, felt, and did preceding his or her death. This procedure was formerly referred to as a psychological autopsy, however, that term is now reserved for equivocal death investigations requested by the Armed Forces Medical Examiner when the manner of death (for example, suicide versus accident) is not readily apparent. The behavioral analysis review is conducted using similar methodology in cases of known suicide. This reconstruction is based upon information gathered from personal documents, police reports, medical and coroner's records, and face-to-face interviews with Families, friends, and others who had contact with the person before the death. The purpose of the behavioral analysis review is to—

- (1) Resolve cases where there is an equivocal cause of death.
- (2) Provide the victim's commander with information about the death.
- (3) Enable the unit and the Army to develop future prevention programs and capture lessons learned so that Soldiers and Family members are better served.

b. The retrospective analysis of deaths serves to increase the accuracy of reports and promotes the epidemiological study of suicide in the military population. A review of the status of the victim with those who had a special relationship with him or her prior to the act (for example, supervisors, coworkers, physician, relatives, and friends) provides a source of information for future prevention actions.

c. When results of the behavioral analysis review are available, offices responsible for examining investigative findings (for example, CID, USAPHC, ASPP, and SPTF), determining trends, pulling data points, and capturing and/or distributing lessons learned follow guidelines outlined in AR 600-63 to utilize the results of the behavioral analysis review, to the fullest extent possible. When available, include information from the DD Form 1300 (Report of Casualty), line of duty investigation, and AR 15-6 investigation.

d. The intention of the victim determines whether a death is classified as a suicide rather than an accident. In an equivocal case, it is difficult to evaluate the deceased's intentions, either because the factual circumstances of the death are incompletely known, or because the deceased's intentions were ambivalent, partial, inconsistent, or not clear.

e. At present there are at least two distinct questions that the behavioral analysis review can help to answer—

(1) Why did the individual do it? When the mode of death is clear and unequivocal, the behavioral analysis review can serve to enhance our understanding of the factors that led to the act. When the manner of death is clear, but the reasons for the manner of dying remain puzzling, the behavioral analysis review is a reconstruction of the motivations, philosophy, psychodynamics, and existential crisis of the decedent.

(2) What is the most probable mode of death? When the cause of death can be clearly established but the mode of death is equivocal, the purpose of the behavioral analysis review is to establish the mode of death with as much accuracy as possible.

B-2. Operational criteria for the classification of suicide

The operational criteria for the classification of suicide that follows were developed to provide a standard definition of suicide for purposes of conducting a behavioral analysis review.

a. *Self-inflicted.* There is evidence that death was self-inflicted. Pathological (autopsy), toxicological, investigatory, and psychological evidence, and statements of the decedent or witnesses may be used for this determination.

b. Intent. There is evidence (explicit and/or implicit) that at the time of injury the decedent intended to kill him or herself or wished to die, and that the decedent understood the probable consequences of his or her actions.

- (1) Explicit verbal or nonverbal expressions of intent to kill him or herself.
- (2) Implicit or indirect evidence of intent to die such as the following:
 - (a) Preparations for death, inappropriate to or unexpected in the context of the decedent's life.
 - (b) Expressions of farewell or desire to die, or acknowledgment of impending death.
 - (c) Expressions of hopelessness.
 - (d) Efforts to procure or learn about means of death or rehearse fatal behavior.
 - (e) Precautions to avoid rescue.
 - (f) Evidence that decedent recognized high potential lethality of means of death.
 - (g) Previous suicide attempt.
 - (h) Previous suicide threat.
 - (i) Stressful events or significant losses (actual or threatened).
 - (j) Serious depression or behavioral health disorder.

B-3. Motivation for suicide

a. The behavioral analysis review should address the motivation for suicide. The reasons, motives, and psychological intentions of an at-risk person are quite complex. Some of the prominent behavioral health trends in at-risk persons are—

- (1) A wish to escape from mental or physical pain.
- (2) A fantasy of eternal rest or life with a loved one.
- (3) Anger, rage, and revenge.
- (4) Guilt, shame, and atonement.
- (5) A wish to be rescued, reborn, or start over.
- (6) A wish to make an important statement or communication.

b. Destructive ideas or impulses that are ordinarily well controlled or mostly unconscious can be activated or released under the influence of emotional stress, physical exhaustion, or alcohol.

B-4. Role of intent

a. The behavioral analysis review should address the motivation for suicide. The reasons, motives, and psychological intentions of at-risk persons are quite complex. Some of the prominent behavioral health trends in at-risk persons are—

- (1) The victim's intention was ambivalent, with coexisting wishes both to live and to die.
- (2) The self-destructive action itself was inconclusive.
- (3) Death followed the action after a considerable delay.

b. Intention is variable in degree, not all or nothing. The concept of intention signifies that the individual understood, to some degree, his or her life situation and the nature and quality of the proposed self-destructive action.

B-5. Classification of suicides by intent

a. One classification system that incorporates the notion of degree of intention and that may be used in the autopsy is as follows:

- (1) First-degree suicide: deliberate, planned, premeditated, and self-murder.
- (2) Second-degree suicide: impulsive, unplanned, under great provocation, or compromising circumstances.
- (3) Third-degree suicide: victim placed his or her life in jeopardy by voluntary self-injury, but the inference is that the intention to die was relatively low because the method of self-injury was relatively harmless, or because provisions for rescue were made.

b. The following are two other categories of self-inflicted death that are not typically classified as suicide because the intention to die cannot be established.

(1) Self-destruction when the victim was psychotic or highly intoxicated from the effects of drugs or alcohol. These circumstances suggest impaired capacity for intention.

(2) Self-destruction due to self-negligence. This last category of death has been described as sub-intentioned death. A sub-intentioned death is a death in which the decedent plays some partial, covert, or unconscious role in his or her own demise. Evidence for this ambivalence toward life may be found in a history of poor judgment, excessive risk-taking, abuse of alcohol, misuse of drugs, neglect of self, a self-destructive lifestyle, a disregard of prescribed life-saving medication, and other actions where the individual fosters, facilitates, exacerbates, or hastens the process of his or her dying. In terms of the traditional classification of manner of death (natural, accidental, suicide, and homicide), some instances of all four types can be subsumed under this category, depending on the particular details of each case.

B-6. Lethality

a. The behavioral analysis review should also address the issue of the lethality of the suicidal behavior. Although the victim's intention to die is the factor used to classify his or her death as a suicide, the amount of lethality involved may be used to discriminate among the various degrees of suicide. Lethality is the probability that the suicidal behavior would result in death.

b. Consideration of the lethality involved permits an evaluation of the individual's drive to self-imposed death. All suicides threats, acts of self harm, attempts, and completed suicides should be rated for their lethality.

c. The lethality of the victim's behavior, whether or not it results in death, may be judged to be in one of four classes: high, medium, low, or absent. This may be accomplished using the lethality of suicide behavior rating scale in table B-1, below. The numerical scale is used to rate the lethality of the suicidal behavior of the victim. The lethality rating is the number of the statement that best characterizes the suicidal act. Lethality is then characterized as being high, medium, low, or absent.

d. The lethality rating derived from the scale below relates to the classification system based on degree of intention as follows:

- (1) A first-degree suicide would require a high lethality rating. There is no doubt as to the victim's intention to die.
- (2) A second-degree suicide may be either rated as high or medium in lethality. The victim knew that the suicidal behavior would likely result in death; however, the act was impulsive and unplanned.
- (3) A third-degree suicide would be rated as being either medium or low in lethality.
- (4) Suicidal behavior resulting in a sub-intentioned death would always be rated as low in lethality.
- (5) Where the capacity for intention is absent or where the victim played no role in effecting his or her own death, it may be said that lethality was absent in the victim's behavior.

Table B-1
Lethality of suicide behavior rating scale

Lethality: Absent

Rating: 0

Statement: Death is an unforeseen or highly unlikely result of the 'suicidal behavior.'

Lethality: Low

Rating: 1

Statement: Death is improbable. If it occurs it would be a result of secondary complications, an accident, or highly unusual circumstances.

Lethality: Low

Rating: 2

Statement: Death is improbable as an outcome of the act. If it occurs it is probably due to unforeseen secondary effects. Frequently the act is done in a public setting or reported by the individual involved or by others. While medical aid may be warranted, it is not required for survival.

Lethality: Low

Rating: 3

Statement: Death is improbable as long as first aid is administered by the victim or other agent. The victim usually makes a communication or commits the act in a public way or takes no measures to hide self or injury.

Lethality: Medium

Rating: 4

Statement: Death is a 50-50 probability directly or indirectly, or in the opinion of the average person, the chosen method has an equivocal outcome.

Lethality: Medium

Rating: 5

Statement: Death is the probable outcome unless there is immediate and vigorous first aid or medical attention by the victim or other agent. One or both of the following are true: Makes communication (directly or indirectly). Performs act in public where he or she is likely to be helped or discovered.

Lethality: High

Rating: 6

Statement: Death would ordinarily be considered the outcome to the suicidal act, unless saved by another agent in a calculated risk (for example, nursing rounds or expecting a roommate or spouse at a certain time). One or both of the following are true: Makes no direct communication. Takes action in private.

Lethality: High

Rating: 7

Statement: Death is the highly probable outcome. Chance intervention and/or unforeseen circumstances may save the victim. Two of the following three conditions also exist: No communication is made. Effort is put forth to obscure act from helper's attention. Precautions against being found are instituted.

Table B-1
Lethality of suicide behavior rating scale—Continued

Lethality: High

Rating: 8

Statement: Death is almost a certainty regardless of the circumstances or interventions by an outside agent. Most of the people at this level die quickly after the attempt. A very few survive through no fault of their own.

B-7. Death investigation team

a. The behavioral analysis review is conducted by a forensically-trained psychiatrist or psychologist and provided to the commander of the local USACIDC activity for inclusion in the report of investigation of the death. In difficult cases where the command desires a more extensive investigation, consideration is given to forming a death investigation team. This is a multidisciplinary approach involving the collaboration of a pathologist or other medical officer with behavioral health officers in the areas of psychiatry, psychology, psychiatric nursing, and social work, and a law enforcement officer.

b. The developers of the behavioral analysis review procedure have emphasized that an outline or accumulation of postmortem data alone is not a behavioral analysis review. The information should include the personal responses of each member of the death investigation team. Team members report in their areas of expertise and participate in mutual exchanges of information. The completed reports should represent a consensus of the views of the team members.

B-8. Procedure for behavioral analysis review

a. The behavioral analysis review typically consists of interviews of persons who knew the deceased (such as spouse, parents, children, neighbors, supervisor, coworkers, friends, and physicians) in an attempt to reconstruct the lifestyle of the deceased. This is usually done jointly with a law enforcement officer to facilitate mutual access to persons and records. In the investigation, an attempt is made to obtain relevant information about any psychiatric idiosyncrasies or the presence of any suicide warning signs the victim may have voiced.

b. The following information should be gathered by the investigating officer or team:

- (1) Life history.
- (2) Psychiatric-psychological data.
- (3) Clues to or communications of suicide intent.
- (4) Recent life events.
- (5) Miscellaneous data that may be relevant to the death, but not necessarily psychological in nature (for example, physical evidence from the scene of the death).

c. As a preliminary step in conducting a behavioral analysis review, review the following data:

- (1) Inpatient and outpatient medical records.
- (2) Physical autopsy (necropsy) report including toxicology results.
- (3) Law enforcement and CID investigation results.
- (4) Line of duty investigation report.
- (5) Any records existing in the Community Mental Health Service, hospital departments of psychiatry and social work, ASAP, FAP, or other Army programs.

B-9. Behavioral analysis review report

The following is a guide for preparing behavioral analysis review reports and should be used unless there are special considerations. The categories below should be included:

a. Identifying information. As a preliminary step in conducting a behavioral analysis review, should review the following data:

- (1) Name.
- (2) Rank and/or grade.
- (3) Social security number.
- (4) Age and date of birth.
- (5) Sex.
- (6) Race.
- (7) Marital status (married, single, divorced, widowed, separated).
- (8) Military occupational specialty.
- (9) Unit and/or station.
- (10) Level of education.
- (11) Home address (where victim was living at time of death).

b. Investigative method. Method of gathering information and identification of sources contacted.

c. Details of death.

- (1) Date and time (provide date and time of suicidal act and death if different).
- (2) Location (address and description, that is, friend's house, parents' home, victim's off-post residence, motel, and so forth).
- (3) Method.
- (4) Details of discovery.
- (5) Provisions for rescue (describe).
- (6) Suicide note content.
- (7) Communication of suicidal intent.
- (8) Acts of violence that accompanied the suicidal act.
- (9) Other details.

d. History of prior suicide attempts.

- (1) Dates and descriptions of prior attempts and threats.
- (2) Provisions for rescue.
- (3) Circumstances surrounding suicide attempts.

e. Physical autopsy (necropsy) results.

- (1) Cause of death.
- (2) Blood alcohol and other toxicology results.
- (3) Describe any evidence of disease process.
- (4) List and explain significant abnormalities.

f. Personality and lifestyle.

- (1) Basic personality (relaxed, intense, jovial, gregarious, withdrawn, outgoing, morose, bitter, suspicious, angry, hostile, combative, mild-mannered, others).
- (2) Describe the victim's recent changes in mood or symptoms of behavioral health illness.
- (3) Describe the victim's recent changes in behavior, such as eating, sleeping, sexual patterns, drinking, driving, taking pills, social relationships, or hobbies.
- (4) Stress reactions as follows:
 - (a) Describe the victim's normal reaction to stress.
 - (b) Describe the typical patterns of stress reactions.
 - (c) State recent losses, if any.
- (5) Interpersonal relationships as follows:
 - (a) Describe the victim's interpersonal relationships (few, casual, or intense).
 - (b) State recent uncharacteristic behavior of the victim such as withdrawal from friends, gambling, spending, promiscuity, and fights.
 - (c) Describe the victim's friendship group.
 - (d) Describe the manner in which the victim's time was spent.

g. Marital and/or couple relationship history.

- (1) Marital status.
- (2) Category of dyad trouble.
- (3) Nature of dyad trouble.
- (4) Number and length of marriages.
- (5) Current living arrangements.
- (6) Number, age, and sex of children.
- (7) Location where children live?
- (8) Changes in relationship with spouse or children.
- (9) Threats of or actual divorce or separation.
- (10) Recent deaths in Family.
- (11) History of abusive behavior.
- (12) Overall quality of current relationship.
- (13) Dating history.

h. Family of origin history.

- (1) Describe parents' marital history.
- (2) Family medical history.
- (3) History of Family member psychiatric hospitalizations and treatment.
- (4) Family suicide history.
- (5) Number, age, and sex of siblings.
- (6) Family history of sexual abuse or other forms of child abuse or Family violence.

- (7) Family history of alcoholism or other substance abuse.
- i. Family history.* Death history of victim's Family (suicides, cancer, other fatal illnesses, accidents, ages of death, and other details).
- j. Past problems.* Describe any trouble, pressures, tensions, or anticipated problems during the past year.
- (1) List and describe any observed or expressed symptoms of depression.
 - (2) List and describe any observed immediate danger signals.
- k. Work history.*
- (1) State the victim's occupation.
 - (2) State the victim's level of satisfaction from work (excellent, good, fair, or poor).
 - (3) State the victim's employment history (job loss, promotion, or retirement).
- l. Military history.*
- (1) Time in service.
 - (2) Time in grade.
 - (3) Months assigned to present unit.
 - (4) Date of last permanent change of station.
 - (5) Date of pending permanent change of station.
 - (6) Date of last date eligible for return from overseas.
 - (7) Awards.
 - (8) UCMJ actions (Article 15, court-martial).
 - (9) Pending unfavorable personnel actions (bar to reenlistment, weight control program, other).
- m. Medical history.*
- (1) Describe significant illnesses and treatment.
 - (2) Describe recent loss or change in health status.
 - (3) Describe any injuries, accidents, or hospitalizations.
 - (4) List current medications and history of compliance.
 - (5) Human immunodeficiency virus positive or not.
- n. Psychiatric history.* Hospitalizations, psychotherapy, or other therapy.
- (1) If so, state when and for how long.
 - (2) Describe the diagnosis and nature of treatment.
 - (3) Describe victim's use of psychotropic medications or sleeping pills.
 - (4) State evidence of a personality disorder or difficulties.
- o. Alcohol history.*
- (1) Describe role of alcohol or drugs in the victim's overall lifestyle and death.
 - (2) State the victim's usual alcohol consumption.
 - (3) Identify the victim's behavior changes when drinking and drunk.
 - (4) State the evidence of addiction to alcohol and include the number and dates of detoxifications.
 - (5) State when and where the victim was enrolled in ASAP.
- p. Drug abuse history.*
- (1) Identify drugs the victim used, if any.
 - (2) State if the victim was addicted to drugs.
 - (3) State the number and dates of detoxifications.
- q. Financial status.* Describe the victim's financial situation (recent losses, business successes or failures).
- r. Legal history.*
- (1) Describe the victim's legal actions, if any.
 - (2) State the victim's criminal record (number and length of jail or prison terms, nature of the offenses).
 - (3) State if the victim was absent without leave (AWOL) or a deserter at the time of the suicide. Provide dates of AWOL or desertion.
 - (4) State if the victim had been accused of sexual misconduct or other sexual deviations.
- s. Recent agency contacts.* List and describe all contacts with any of the following agencies during the past year.
- (1) Behavioral health.
 - (2) Chaplain (to the extent no confidential communication is disclosed).
 - (3) Physician.
 - (4) Legal assistance (to the extent no privileged information is involved).
 - (5) Army Emergency Relief.
 - (6) ACS.
 - (7) FAP.

- (8) ASAP.
- (9) Civilian agencies.
- t. Indications of increased suicide risk.*
- (1) List and describe any observed or expressed symptoms of depression.
- (2) List and describe any observed immediate danger signals. Describe the response of the observer to the danger signals.
- u. Duty performance, if any.*
- (1) Work or assignment related problems.
- (2) Problems in accepting Army life.
- (3) Recent changes in duty performance.
- (4) Accidents.
- (5) Problems with personal hygiene and/or appearance.
- (6) Problems with being late or missing work.
- (7) Problems with the quality of work.
- (8) Relationship problems with supervisors, peers, and/or subordinates.
- (9) State the victim's display of emotional state as seen by others in the work environment.
- v. Deployment history.*
- (1) Did the victim have orders to deploy?
- (2) Did the victim refuse to deploy?
- (3) Was the suicide event related to a deployment (past or present)?
- (4) If deployed when suicide occurred, describe dates, location, environmental conditions, and duties of the deployment at time of death.
- (5) Start date of deployment, length of deployment, and location.
- (6) Provide a history of deployments prior to the time of death.
- w. Specific issues relating to deployment and combat.*
- (1) Did the victim experience direct combat operations?
- (2) Did the victim and his or her unit engage in battle resulting in casualties or wounded?
- (3) Did the victim become wounded or injured in combat?
- (4) Did the victim personally witness a unit member, ally, enemy, or civilian being seriously wounded or killed in combat?
- (5) Did the victim see the bodies of dead Soldiers or civilians following the battle?
- (6) Did the victim kill others in combat?
- x. Assessment of intention.*
- (1) State the role of the victim in his or her own demise.
- (2) Determine the rating of lethality (see table B-1).
- (3) State if the victim reasonably expected and wished to die as a result of his or her suicidal behavior.
- y. Summary and conclusions.*
- (1) State whether, in the opinion of the investigator or death investigation team, this death was a suicide.
- (2) Estimate the victim's subjective state at the time of suicide.
- (3) If this death was a suicide, determine classification (first, second, or third-degree suicide, sub-intentioned death).
- (4) State the most probable reasons for the victim's decision to commit suicide (factors immediately contributing to the suicidal behavior, precipitating events).
- (5) State if the victim's commander, supervisor, or the medical system identified a problem before the suicide took place.
- (6) State if the suicide was—
 - (a) A bad outcome following reasonable command attention and medical care.
 - (b) The product of a system failure or inadequate medical care.
- (7) State what actions, if any, could have been taken by those who had a special relationship with the victim (supervisors, coworkers, physician, Family, and friends) that would have led to the anticipation and prevention of this suicide. State what could have been done to lower the risk of suicide in this case.
- (8) Provide comments, special features, lessons learned, and usefulness and relevance of available suicide prevention training materials in this case.

B-10. Special considerations

For each method of suicide explore the following:

a. Gun shot.

- (1) The victim's knowledge, experience, and training with firearms.

- (2) The victim's history of handling weapons recklessly or cautiously.
- (3) The victim's prior firearms accidents.
- (4) The victim's recent purchase of a firearm.
- (5) Describe whether victim used military or duty weapon, or own personal weapon.

b. Overdose.

- (1) State the victim's knowledge of drugs and their potential dangers (prescribed or street drugs and the amount).
- (2) Were there premature refill requests?
- (3) Was the victim ever seen under the influence of drugs?
- (4) What was the victim's behavior under the influence of drugs?
- (5) Was there a history of prior overdoses and how were they treated?
- (6) Was the victim careless in the use of medications, taking more than prescribed?
- (7) How did the victim keep track of pill intake?
- (8) What were other sources of pills?

c. Hangings or asphyxia.

- (1) Explore for sexual involvement.
- (2) How was the victim clothed?
- (3) When found, state if pornographic material or sexual paraphernalia was nearby.
- (4) State the victim's known sexual activity (deviance, reading material, interests, knowledge of asphyxia techniques, and experience with rope).

d. Jumping, drowning, vehicular death, fire, other method.

- (1) State the reason for the victim to be at the place of death.
- (2) With respect to the specific method, state the victim's habitual behavior.

Appendix C

Commander's Policy Letter

C-1. Commander's policy letter requirement

A commander's Health Promotion policy letter is required for commanders at all level (in accordance with AR 600-63, para 1-31a.)

C-2. Sample

A sample commander's policy letter is shown below in figure C-1.



DEPARTMENT OF THE ARMY
ORGANIZATION NAME/TITLE
STANDARDIZED STREET ADDRESS
CITY, STATE, ZIP + 4 CODE

REPLY TO
ATTENTION OF

OFFICE SYMBOL

DATE

MEMORANDUM FOR SEE DISTRIBUTION

SUBJECT: Command Policy Letter for Health Promotion, Risk Reduction, and Suicide Prevention

1. References:

2. The readiness of our Army is paramount in our ability to fight and win on the battlefield. Sustaining the health and wellbeing of our Soldiers, Family members and DA civilians is a preeminent responsibility of Army senior leaders and personnel at all levels. The Army's strategic approach to mitigating suicide and high-risk behavior helps build cohesive units. Promoting healthy lifestyles, reducing risk-seeking behavior and preventing suicide are priorities in this Command.

3. All commanders, leaders, supervisors, Soldiers and DA civilians are responsible for creating an environment that reduces the stigma of seeking help for behavioral health issues. On a daily basis, it is incumbent on all of us to be aware of and recognize when someone may be at risk, and to be empowered to take appropriate action to save lives. Each of us is responsible for eliminating policies, procedures, and actions that inadvertently discriminate, punish, or discourage Soldiers or employees from seeking professional counseling.

4. To this end, ensure that no Soldier is belittled for requesting assistance from behavioral health professionals and social workers. Similarly, ensure civilian employees are encouraged to access help available for them. Leaders will utilize an extraordinary degree of discretion when identifying and sharing information regarding Soldiers and civilian personnel seeking help.

5. Each life lost to suicide is one life too many. Suicide prevention spans the gamut of effort from prevention to intervention to post-intervention. Each one of us has a personal role to play in preventing suicide. Task forces (such as the Community Health Promotion Council) and teams identify trends. Annual training and refresher training provide information for intervention. Response teams assist the commander in the event of a suicide.

6. There are numerous resources available for those in need of help. ***(List some of them here)*** From a fundamental perspective, the Army's "ACE" – Act, Care, Escort – initiative reflects this command's perspective on caring for the Army's most vital resource, our Soldiers.

7. POC for this action is Mr. John Doe at (444) 555-1212, FAX (444) 555-1213 or email:
john.b.doe@us.army.mil.

//Signed//

JOHN Q. PUBLIC
Rank, XX
Commanding

Figure C-1. Commander's policy letter - sample

Appendix D Resources

D-1. General

The following are samples of available resources for Soldiers, Army Civilians, and Family members.

D-2. List of resources

a. Hotlines.

(1) The National Suicide Prevention Lifeline (1-800-273-TALK/8255) is sponsored by the United States Department of Health and Human Services. Military callers have an option of “pressing 1” to connect to the Military Crisis Line to speak with a veteran’s representative or a crisis center in their local area. The veteran’s representative has access to United States Department of Veterans Affairs (VA) records and can work with the caller on VA registration and ensures a warm hand-off to VA services.

(2) The Wounded Soldier and Family Hotline (1-800-984-8523) is hosted by the ARNG and provides support to Soldiers and Families. During hurricanes, floods, and other declared emergencies, services are expanded to become a 24 hour a day, 7 day a week resource.

(3) A comprehensive listing of hotlines by state can be found at <http://www.suicide.org/suicide-hotlines.html>.

b. Other resources.

(1) Military OneSource (1-800-342-9647; <http://www.militaryonesource.com>) is a source for a wide array of call-in services. The phone is always answered by an individual who is a professional counselor with Master’s Degree-level qualifications. TRICARE Mental Health Resource Center provides information on how to secure medical assistance for military members and their Families. The services are not limited to behavioral health issues, but extend across the full spectrum of TRICARE services. The Web site is <http://www.tricare.mil/mentalhealth/Default.aspx>.

(2) The Substance Abuse and Mental Health Services Administration (<http://www.samhsa.gov>) helps leaders locate behavioral health resources in the communities in which Soldiers live. The state locator maps out resources by state and provides contact information.

(3) Army Knowledge Online (AKO) (<https://www.us.army.mil/suite/login/welcome.html>). This site requires a common access card and AKO account to access.

(4) National Commission for Health Education Credentialing, Inc. (<http://www.nchec.org>).

(5) Institute of Medicine of the National Academies (<http://www.iom.edu>).

(6) American Alliance for Health, Physical Education, Recreation and Dance (<http://www.aahperd.org/index.cfm>).

(7) USAPHC has presentations that include video interviews and vignettes. In addition, tip cards for enhancing resiliency and for identifying suicide risk factors accompany these presentations. The presentations can be found on USAPHC’s AKO suicide prevention Web site at <https://www.us.army.mil/suite/page/334798> (requires a common access card and AKO account to access).

Glossary

Section I Abbreviations

ACE

ask, care, escort

ACE-SI

ask, care, escort-suicide intervention

ACOM

Army command

ACS

Army Community Services

ADCO

Alcohol and Drug Control Officer

AKO

AR

Army regulation

ARNG

Army National Guard

ASAP

Army Substance Abuse Program

ASCC

Army service component command

ASPP

Army Suicide Prevention Program

AWOL

absent without leave

CBHS

Community Behavioral Health Services

CHPC

Community Health Promotion Council

CID

Criminal Investigation Command

CSF2

Comprehensive Soldier and Family Fitness

CSSER

Commander's Suspected Suicide Event Report

DCS, G-1

Deputy Chief of Staff, G-1

DHAP

Deployment Health Assessment Program

DOD

Department of Defense

DODI

Department of Defense instruction

DODSER

Department of Defense Suicide Event Report

DRU

direct reporting unit

FAP

Family Advocacy Program

HCP

health care provider

HIPAA

Health Insurance Portability and Accountability Act

HQDA

Headquarters, Department of the Army

IDT

inactive duty training

IPT

installation prevention team

JFHQ

Joint Forces Headquarters

MFLC

Military Family Life Consultant

MHA

Mental Health Assessment

MTF

military treatment facility

NCO

noncommissioned officer

OCONUS

outside the continental United States

OSD

Office of the Secretary of Defense

PHA

periodic health assessment

PTSD

post traumatic stress disorder

R-URI

re-integration unit risk inventory

R2C

Ready and Resilient Campaign

RRP

Risk Reduction Program

RRPC

Risk Reduction Program Coordinator

SAT

Staff Assistance Team

SI

suicide intervention

SPPM

Suicide Prevention Program Manager

SPTF

Suicide Prevention Task Force

SRT

Suicide Response Team

SSART

Specialized Suicide Augmentation Response Team

TBI

traumatic brain injury

TRICARE

Tri-service medical care

UCMJ

Uniform Code of Military Justice

URI

unit risk inventory

USACIDC

U.S. Army Criminal Investigation Command

USAPHC

U.S. Army Public Health Command

USAR

United States Army Reserve

USC

United States Code

VA

Veterans Administration

Section II**Terms****behavioral health provider**

Those trained behavioral health professionals who are credentialed or licensed as psychiatrists, clinical or counseling psychologists, social workers, or psychiatric clinical nurse specialists.

equivocal death

Cases in which the available facts and circumstances do not immediately distinguish the mode of death. A death is equivocal when ambiguity or uncertainty exists between any two or more of the four modes.

gatekeepers

Individuals who, in the performance of their assigned duties and responsibilities, provide specific counseling to Soldiers and Army Civilians in need. Gatekeepers receive training in recognizing and helping individuals with suicide-related symptoms or issues. Gatekeepers can be identified either as primary gatekeepers (whose primary duties involve assisting those in need who are more susceptible to suicide ideation) or secondary gatekeepers (who may have a secondary opportunity to come in contact with a person at risk). See AR 600–63, table 4–1 for examples of primary and secondary gatekeepers.

geographically-dispersed

Organizations or individuals who are not centrally located on a military installation. This primarily refers to USAR and ARNG units and personnel whose cohesion is disrupted by distance, but also includes Active Army Soldiers who live and work more than 50 miles from an installation, such as recruiters.

intervention

Actions undertaken to prevent an individual experiencing a life crisis or a behavioral health disorder from committing suicide. Examples include listening, showing empathy, and escorting a person to receive help.

mode of death (also known as manner of death)

Four categories of death: natural, accident, suicide, and homicide. The four modes of death have to be distinguished from the many causes of death such as gunshot wound or a disease process. When the mode of death is unknown, a fifth category, undetermined, is often used.

postvention

Those actions taken after an incident of suicidal behavior that serve to moderate the effects of the event on the survivors of a person who has completed or attempted suicide.

prevention

A continuum of awareness, intervention, and postvention. All efforts that surround building resiliency, reducing stigma, building awareness, and strategic communication.

psychological autopsy

Attempts to clarify the nature of death by focusing on the psychological aspects of the death. Its primary purpose is to understand the circumstances and state of mind of the victim at the time of death. The procedure involves the reconstruction of the lifestyle and circumstances of the victim, together with details of behaviors and events that led to the death of the individual.

self-harm

A self-inflicted, potentially injurious behavior for which there is evidence (either explicit or implicit) that the person did not intend to kill himself or herself (that is, had no intent to die). Persons engage in self-harm behaviors when they wish to use the appearance of intending to kill themselves in order to attain some other end (for example, to seek help, punish others, to receive attention, or to regulate negative mood).

social networking

Web sites that build online communities of people who share interests or activities, or who are interested in exploring the interests and activities of others.

suicide attempt

A self-inflicted, potentially injurious behavior with a nonfatal outcome for which there is evidence (either explicit or implicit) of intent to die. A suicide attempt may or may not result in injury. Therefore, this category includes behaviors where there is evidence that the individual intended to die, but the event resulted in no injuries.

Section III**Special Abbreviations and Terms**

This section contains no entries.

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